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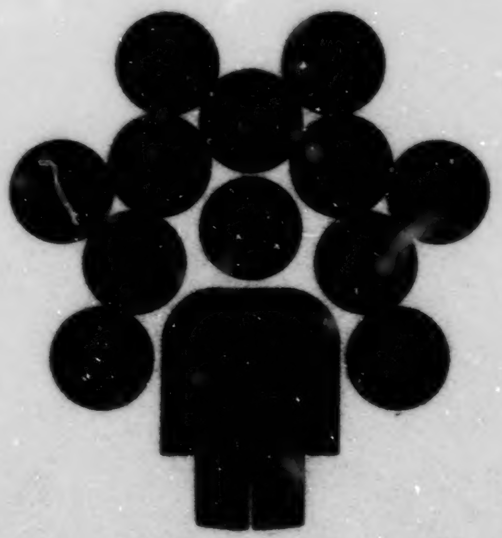

Health and Welfare Canada
Santé et Bien-être social Canada

HANDBOOK
FOR
RURAL MENTAL HEALTH WORKERS:
PERSONAL, PROFESSIONAL,
AND PROGRAM SURVIVAL

Mental Health Division
Health Services Directorate
Health Services and Promotion Branch
in co-operation with the Canadian Mental Health Association
(British Columbia Division) and the British Columbia
Ministry of Health

Published by authority of the
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Opinions expressed in the articles of this Handbook are the responsibility of their respective authors, and do not necessarily reflect the official policy of the Department of National Health and Welfare, the British Columbia Ministry of Health, or the Canadian Mental Health Association.

Également disponible en français
sous le titre

"Manuel pour les travailleurs de la santé mentale en milieu rural:
survie personnelle et professionnelle, et
continuité des programmes"

In September of 1981, in a beautiful lakeside setting near Kelowna, British Columbia, rural mental health workers from Manitoba, Saskatchewan, Alberta and British Columbia met to address issues of personal, professional, and program survival. The theme of the Sixth Western Inter-Provincial Conference on Rural Mental Health was "Community Mental Health - An Endangered Species?" Participants from many regions and disciplines shared their responses to the special problems and opportunities that occur in rural service delivery. In order that this sharing of resources, reflections and strategies might be extended to rural mental health workers across the country, the organizers resolved to publish a Handbook based on the proceedings of the Conference. After an initial planning session, the cooperation of the many speakers and presenters was enlisted, and the Editorial Committee began assembling and editing material for three chapters corresponding to the three days of the Conference. This lengthy process completed, the Section Editors forwarded their chapters to the Mental Health Division, Health and Welfare Canada, which provided funding and staff time for consultation, final editing, and publication.

Like all collective or communal efforts, the resulting Handbook reflects a variety of viewpoints, styles and approaches; indeed, it was found that the three topic areas lent themselves to rather different editorial treatment. The Section Editors would like to thank Thomas J. Lips of the Mental Health Division, who carried out the final editing and supervised the publication of the Handbook.

From practical, "cookbook" guidelines to philosophical reflections regarding values, methods, and goals, the articles contained herein demonstrate the resourcefulness, commitment, and determination of Canada's rural mental health practitioners - qualities that augur well for the survival and development of this important area of service.

The Editorial Committee

PREAMBLE: THE WESTERN INTER-PROVINCIAL CONFERENCE ON RURAL MENTAL HEALTH

The de-institutionalization of the mentally ill and the concomitant development of a decentralized Community Mental Health System gave rise to a host of problems which were largely unanticipated at the outset of the movement. Not the least of these unanticipated problems were the very unique needs of rural mental health practitioners.

Historically, mental health practice was largely an urban phenomenon practiced almost exclusively in institutional settings. Even after the de-institutionalization process had begun, urban mental health workers were supported in their practice by urban-based colleagues who, like themselves, had regular access to large urban-based educational institutions, and to the relatively plentiful resources of the large urban community. They rarely experienced the problems associated with professional isolation, and their personal life was a thing set apart from their professional milieu.

With the advent of the rural mental health movement in the 1960's and early 1970's, however, the entire fabric of professional practice was profoundly altered. Mental health practice in rural areas usually implied solo practice, devoid of the professional support of colleagues, without the benefit of treatment alternatives and support systems, and lacking in consultative opportunities. The practitioner had become a very big fish in a small pool -- conspicuous often as a public and professional figure, faced often with the difficulty of separating personal and social life from professional milieu, and finding that time for personal needs was an increasingly rare commodity.

These special problems of rural practice were first addressed by the four Western Provinces in 1975. The occasion was the first Western Inter-Provincial Conference on Rural Mental Health - a conference which has been a recurring event for Western rural practitioners on five other occasions under rotating provincial auspices since that time. Consistent throughout all of these conferences has been the realization that the special needs of rural practice were common across all of the Western Provinces, and that rural professionals from the different provinces shared more concerns with each other than they did with urban practitioners from within their own respective provincial mental health systems.

The theme set for the 1981 Rural Mental Health Conference captured a common thread linking all five previous conferences: personal, professional and program survival issues in rural mental health practice. This publication contains the contributions of numerous professional and volunteer staff who know the special problems associated with rural practice. Readers of the professional literature will appreciate this unique compendium for its "state of the art" assessment of rural mental health practice in Western Canada in 1981, and for the special concerns it raises.

Since its inception, the Western Inter-Provincial Conference has been designed to incorporate both the voluntary and the professional sectors in all of its conference activities. This linkage was highlighted more in 1981 than in any previous conference. The 1981 conference was constituted under the joint sponsorship of the Ministry of Health for British Columbia and the Canadian Mental Health Association's British Columbia division. Such organizational collaboration is in itself characteristic of the type of professional-volunteer relationships that one often finds in rural practice. The increasing emphasis placed upon collaborative activity shows the mutual benefits of linkages and cooperative activity between the professional and the volunteer networks.

On behalf of rural mental health practitioners, both volunteer and professional, throughout Western Canada, the Inter-Provincial Planning Committee would like to express its sincere appreciation to the various Provincial Ministries that have secured the funding necessary to make these valuable conferences a reality. The Committee would also like to extend its appreciation to the Mental Health Division, Health and Welfare Canada, for its continuing interest and support of these conferences and, in particular, for the funding of this publication.

Inter-Provincial Planning Committee
Western Inter-Provincial Conference on Rural Mental Health:

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Mr. Denny Barr, Alberta	Mr. John Farry, Chairman, British Columbia

January 14, 1983

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The following is a list of members of the Continuing Education Committee, Mental Health Services, British Columbia Ministry of Health. This Committee worked closely with the Inter-Provincial Planning Committee and the Canadian Mental Health Association (B.C. Division) in planning and organizing the 1981 Conference upon which this Handbook is based.

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REFLECTIONS ON COMMUNITY MENTAL HEALTH

Dr. Frank McNair, Director of Psychiatric Services,
Kelowna General Hospital; Clinical Assistant Professor
of Psychiatry, University of British Columbia

This paper is based on the keynote address prepared by Dr. McNair for presentation at the Sixth Western Inter-Provincial Conference on Rural Mental Health (Kelowna, September 13-17, 1981).

Like many of the people who will read this Handbook, I am a mental health worker with strong roots in the community mental health movement. I would like to express my deep appreciation for this opportunity to share some thoughts about the challenges and opportunities confronting mental health workers in rural community mental health settings. The starting point for my remarks will be the Community Mental Health Centre; however, many areas of concern will be familiar to those working in other contexts.

"Aliens"

We deal with people who are alienated. Not all the "aliens" are our responsibility, but we have to come to terms with the schizophrenic, who is the most alienated of all. Our task is not made easier by a social tradition that has decreed that those who work with such aliens are also alien. The movement of patients from institution to community has provided a number of challenges.

Shortly after we opened British Columbia's first Mental Health Centre in Kelowna in 1962, one of our boarding home patients was charged with stealing a barbecued chicken worth $1.69. He was taken to jail and to court. The magistrate wanted to know if he was fit to stand trial. Explanations about a movement of mental patients from custody to community, and the resulting transition difficulties, did not satisfy him. Pushed for an unequivocal response, I gave the opinion that the man knew he had done wrong - so he was sentenced to 3 months in jail. On his return the same magistrate summoned 2 family doctors and had him certified back to the mental institution. When you are an alien, justice is apt to be coloured by prejudice. Unhappily the story of society's management of the schizophrenic is a story of lost rights, lost freedom, lost family contact - an experience of being despised and persecuted.

For all of us, a fundamental task in living is to solve the problem of loneliness. Time to be solitary can be a boon, but lonely time is painful. Learning when and how to share but also to have privacy boundaries is necessary for our growth. Encountering misfortunes first hand, or indirectly through friends, we respond with sensitivity to the loneliness of pain, of grief and of dying. But for the various disorders we call schizophrenia, the common factor is the "glass wall" across which we have difficulty establishing the meaning of things. Even language has a different connotation, often being used for a magical purpose rather than for communication. Unable to use his language symbols appropriately, the schizophrenic patient's own intelligence is not fully available to him for learning and problem-solving. In consequence he lacks many social skills and survival skills and is regarded by his fellows as inept.

To help him be a part of society we look for an initial social tolerance. We strive for a personal rapport, hoping for the development of trust. We may provide alternative social settings in residence, workshop or hospital ward. A continuum of services is required for his habilitation - this word rather than "rehabilitation" as he often lacks basic learning for social life and independence. And in all these efforts we may have made our first acquaintance through someone's rejecting and discarding techniques rather than through a referral system which would make for a better start in establishing a helping relationship.

Credibility

It is vital that our Mental Health Centre and its personnel have credibility. The only sure route to credibility is by service. We have to be accessible and willing to help, particulary in emergencies, yet have the diplomacy to maintain respect and not have our good will imposed on. The spectrum of our services will include house calls. Sometimes we need reminders that before the Mental Health Centre arrived on the scene, the staff of the social agencies were dealing with many of the community's most difficult social problems. We are looked to as a major resource for them.

A close working relationship with the psychiatric unit at the hospital is also a must. The ward is the back-up resource for most of the emotional crisis events in the community.

Hospital emergency departments are not thrilled to look after people in emotional and family crisis. Many such clients have been drinking; all are disruptive of the emergency routines that relate to heart attacks and motor vehicle accidents. When the psychiatric nursing staff find someone dropped off on the ward with a terse "he's yours," they are not ecstatic. Neither are the emergency staff when confronted with an overdosed patient whose pills have been prescribed by the psychiatrist. So our own response to these tensions was to call a meeting for the off-duty nurses of psychiatry and emergency together with the Mental Health Centre staff. The most constructive result of that meeting was the restoration of courtesy - the phone call that says "we have a problem here, can you help?" It still works; we like to be needed.

Coping

Let us consider 'coping.' So often we are caught up in problems. We enumerate symptoms. The new record system at the hospital is the 'problem oriented' approach. My plea is for equal time for the assets of our patients or clients. What do they have going for them? One day a 25-year-old single man came to my office to complain that his work-mates made fun of him. He was a tall ungainly fellow, an immigrant. Apart from his striking height - he must have been 6'4" - the most striking features about him were his long neck and his big nose. His fellow workers called him "Big Bird" and he produced the cover of a magazine to show me what they meant. I was speechless briefly but lied successfully that I did not see the resemblance. We found a number of common interests to share and in subsequent interviews we identified his strength, his industriousness, his ambition and his compassion as features of his make-up around which he could build his feelings of self worth.

The larger question arises, how do any of us cope? After all, most of the species that have inhabited Planet Earth are now extinct. Dr. David Hamburg has made a study of coping techniques and finds there are 3 basic motivational forces: survival, self-esteem, and belonging to a group. For our own coping capacity as well as our professional success, it is worthwhile to review some of the techniques that Hamburg has noted:

1. We strive to minimize the threat. Often we begin by denial, then gradual acceptance and assimilation.

2. We share our experience with an available listener, maybe one who is 'in the same boat.' We try for mutual aid. It has been found that social strengths are of greater significance in coping than traits identified as personality attributes or deficiencies.

3. We gain emotional support from close relationships.

4. We learn to set intermediate goals. We may have to test a variety of approaches in problem solving.

5. We review the personal meaning of the situation. The immediate issue may be undermining our feelings of personal worth, so we search out other aspects of our worth for reassurance and perspective. We come to terms with reckoning how much of the threat is external and how much is internal because of the meaning we have ascribed to it.

6. We look for better objectivity by getting salient information.

7. We discover that we have learned in the past and can learn in the present circumstances from our adversity. We can deal with our problems one at a time in sequence. We require an inner stockpile of buffers against disappointment. We transfer difficulties from the 'unfamiliar' to the 'familiar' category. We find that knowledge that applied in one setting can apply to an apparently new and different setting.

Evolution of Service Delivery

So many services have to be developed in a rural community. In the sixties a Vanier "Conference on the Family" was held in Toronto. The conference organizers arranged for committees to meet locally to discuss local issues and send delegates. The conference thus provided a focus in our community for a productive encounter between welfare agencies, probation services, a school counsellor, a paediatrician, some family doctors, clergy, public health and mental health staff.

As an immediate result we found a solution for a problem in our town that had been neglected much too long. It had been the practice to detain newborn babies awaiting adoption in the hospital nursery for 3 weeks. No newborn should be denied bonding to a specific 'mother' rather than tending by a series of nurses on shift duty. So foster home care of the newborn was started - one of a great series of new resources which the Mental Health Centre had a share in promoting.

We are instigators and participants in building a Health Care Delivery system. Most of us come to this task very ill-prepared. Every community requires a group, be it formally or informally organized, which functions as a Social Planning Society.

Within a year or two of our beginnings as a Mental Health Centre, the mayor named a small committee to organize a group, in cooperation with the United Way, to which city council could refer regarding proposals for new social resources. A Social Planning Society was registered which has since set up an information service, a crisis line, a shelter for abused women, a foster day care service and a community volunteer service. It attracts many new volunteer recruits each year. The original committee has been replaced several times over. Another mayor's committee was a citizens' advisory committee to the family court. Concerned citizens create the opportunity to develop many possible resources, and they must have a say in policy decisions. Directives from a central office, no matter how wise or well-intentioned, cannot exclude the community worker.

There have been many post-war influences to bring about changes in Health Care. New professions have sprung up and training for traditional professions has been greatly enriched. Health and hospital insurance have greatly benefited the funding and scope of mental health care. Treatment has been revolutionized by the advent of the tranquillizers. The press has been a gadfly which has published exposés on institutional abuses and speeded the move to community care. The younger generation have become disillusioned with established authority and have acquired new heroes such as Ralph Nader, who has fostered a much greater critical awareness among consumers.

What about professional roles in the Mental Health Centre? They're changing. Sometimes role distinctions become blurred. Rivalries occur. Professional organizations become more declarative, relative remuneration becomes an issue. The functioning of the centres depends upon teamwork, so team building becomes a major requirement for leadership. It is my opinion that the psychiatrist should be the clinical head but not necessarily the administrator. I reject the "divine right" theory as I also reject the reducing of the psychiatrist's role to that of rubber-stamp prescription writer.

Job appointments should include consultation with a senior person having the same professional role, as should job evaluation. Professional roles can expand but we each need to keep our primary professional role as psychiatrist, nurse, social worker, pyschologist and occupational therapist. At our Centre we were fortunate to hit upon two stratagems that have worked well:

1. In caring for the care givers, a monthly meeting for acquaintance, food, and education helped mental health, hospital, and community agency staff work more closely together.
2. Areas of consultation were assigned each professional within the Mental Health team: the nurse established liaison with public health and hospital nurses, the social worker with other community agencies, the psychologist with the schools and the psychiatrist with the family doctors.

Learning Opportunities

We provide learning opportunities for people who come to us. But we are only one of the resources for new learning which are present in almost every community - resources which include the public library, the Community College and the Recreation Centre for adults; and for the younger generation the Boys and Girls Club, Big Brother, alternative schools, and cadets. The acquisition of new skills spreads beyond academic and vocational education to learning parenting skills, developing better communication, and improving social and marital relationships. The other resources, particularly the community colleges, are becoming adept at providing courses in self-improvement that have much community appeal.

To gain entry to our service you have to exhibit your hurts and often the helplessness that goes with them. But at some point we have to change the focus from sickness to a learning experience, and in so doing we grow along with our patient or client. Both our success and our job satisfaction depend on our continued growth through new learning. Of course the learning process can be frustrated if we succumb to one-track answers, whether the oversimplification be couched in terms of religious experiences or psychiatric theory.

Let me refer to an episode of the comic strip "Beetle Bailey." The psychiatrist gives the not-so-bright private a Rorshach card. He responds, "It's an ink blot. You can't fool me." He is dismissed and replaced by the studious, overweight lance-corporal who sees "the coast of England about 1588. There comes the Spanish Armada. There's the English fleet waiting for them and there's Queen Elizabeth. In the clouds I see a symbolic forecast of the decline of the Spanish Empire," etc. He continues until the psychiatrist snatches the card away with an oath. The nurse receptionist informs the soldier "He's always disappointed if you don't see something sexy."

Jargon is another enemy of thought.

We all enjoy a laugh at the expense of businessmen and politicians over their jargon, often referred to as "gobbledegook." A graph or chart has become a "statistical breakout" or "critical flow path"; a result is a "print-out." Committees are "interdepartment groups," "coordinating groups," or "project groups." A "task force" is a committee with consultants plus a $100-a-day secretary.

Where jargon is concerned, however, we in the human service professions have no occasion for smugness. In a newspaper clipping I happened upon some years ago, the well-known syndicated columnist Russell Baker describes a doctor with a passion for "fat English":

> Getting his patients out of the hospital and back home has become, for this doctor, "the re-entry into society," a technological chore of the sort performed in outer space. Having facilitated their re-entry into society, he will be able to greet them as "functioning members." How dreadful it must be, caged up and antisocial in a beautifully sterilized container for misfits, for a patient to find himself at the mercy of men whose English is fat, who see him as an exercise in engineering and who are determined to turn him into a "functioning member."

Is Community Mental Health a Failure?

There was a debate on this subject at the last annual meeting of the American Psychiatric Association. I want to summarize the salient factors of that presentation:

In the U.S.A. in 1958 there were 559,000 residents of mental hospitals at a cost of $2.00 a day. In 1978 the number has been reduced to 67,000 at a cost of $78.00 a day per person. There has been a corresponding increase in the number of boarding home beds, which has risen by 730%. New ghettos have been created and community facilities have been overloaded. There has been a massive transfer of people from a Health budget to a Welfare budget. The process can be called "deinstitutionalization without planning."

The pressure for change came through public arousal initiated by such books as Deutsch's "The Shame of the States," through the marketing of the major tranquillizers, and also because there was an increased concern for civil liberties. Accordingly, a commission produced a report which recommended the development of Community Mental Health Centres for defined population groups called "catchment areas"; and thus a movement was born. The centres were to have a multidisciplinary staff, give a comprehensive service and have the backing of general hospital beds. But there has been public demand for new services as well as old services, and staffing has not met the workload. Some staffs have been so concerned with the living conditions of their clients that they have diverted their efforts to social activism rather than programs designated as health matters.

Canada has had a similar experience. In British Columbia the drop in mental hospital population over a 20-year period has been from approximately 5000 to about 1500, and 30-odd Mental Health Centres have sprung up. The concept has been a good one, but funding has fallen far short of providing for the task assigned; and unwisely there has been no provision for research, including social research. One thing is sure: we can't go back.

The Community Mental Health Centre system has many flaws, but demonstration models have worked very successfully. Remember that we deal with people least able to speak for themselves. If our programs are to be effective, we must provide accessibility and a continuum of services and follow-up. Provision must be made for appropriate shelter for our clients and for sufficient staff to develop programs which include structured useful activity and training in basic social skills for the chronically ill client.

Our own growth and larger satisfaction in the helping professions comes in doing what we can with what we have and using our vocal chords and our pens to declare what other tools we need to finish the job.

SECTION ONE: "PERSONAL SURVIVAL"

Section Editor: John Anderson, M.A.
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PREFACE: NOTES ON PERSONAL SURVIVAL

by John A. Anderson, M.A.
Greater Vancouver Mental Health Service

The collection of papers presented in this section is a unique and rather ground-breaking effort in many ways. Although the burnout and stress-reduction literature has snowballed since the late seventies, it has been almost entirely urban in orientation. In contrast, these new papers are explicitly written with the pressured rural practitioner in mind. Each contributor was invited largely on the basis of a reputation for much specifically rural know-how concerning the topic in question.

A second contrast with the previously available survival literature is that this section reflects an unusually broad-based involvement of field staff in the creation process. The delegates to the 1978 Inter-Provincial Conference on Rural Mental Health originally explored many of these topics in a plenary session conducted by some pioneering Central Manitoba workers, entitled: "Rural Thrivers: Survival of the Fittest?" The key survival issues identified by rural staff in this session (which included the lengthy "Manitoba...Survival Test") were then re-submitted to each province for possible updating after screening by the 1981 Inter-Provincial planning committee. By that point it was already painfully obvious, in view of the profound social impact of the slumping economy, that many of these survival issues would be far more likely to seriously endanger staff morale, personal resources, and effectiveness in the next several years than ever before. The mandate could not have been clearer.

The third way in which this section reflects leadership on the part of the rural mental health movement is in terms of the down-to-earth candid approach of the contributors. In the first paper, for instance, Dr. Sata foregoes the customary professional distance of the expert, and we accompany him through a fascinating series of life experiences and candid reflections related to community acceptance and to the survival issues addressed separately by other contributors. Although his section is both conceptually and technically rich in substance, the tone is typically earthy. For the most part, the other presenters embody a similar attitude.

The final way in which rural people are breaking new ground here is in the scope and balance of the contributions taken as a whole. They cover the bases well. While scouring the literature on stress, burnout, and survival in connection with workshops for a variety of helping specialists, I have satisfied myself that four basic survival tactics encompass the hundreds of specific recommendations which have presented themselves to me from all sources. I have arbitrarily labelled these clusters of skills as: replenishing, re-structuring, re-negotiating, and re-connecting. Without being told about this framework, each of the chosen contributors has produced an article that exemplifies to some extent one of the above essentials of a well-rounded preventive or corrective approach.

This section of the Handbook could well serve as a collection of readings for a modular professional development "refresher" course, suitable for all staff desiring to thrive throughout economic or any other hard times. Sata's overview would be followed by the following modules which have been roughly sequenced to move from the least to the most socially intimate strategies for reducing or coping with stress:

MODULE ONE: REPLENISHING SKILLS

Tessier presents her own four-fold system (including physical, intellectual, emotional, and spiritual dimensions) for monitoring, combatting, and preventing fatigue. The emphasis in this module is upon developing habits for creating and maintaining vitality through an energy-restoring lifestyle that minimizes weariness by continuously re-charging the emotional batteries. A course module on "replenishing skills" would typically discuss the most widely relied-upon cluster of tactics, including diet, exercise, rest, relaxation, and recreation. One of the subtler (though no less powerful) tactics is greater fascination and positive interest in everyday things. Children may be the best mentors for recapturing this energizing capacity.

MODULE TWO: RE-STRUCTURING SKILLS

Bates and Van Dam apply the Systems theory of change and the psychology of cognitive restructuring to the practical problems of avoiding the exhaustion and collapse associated with the final stages of burnout. They suggest the paradoxical technique of "letting go" from unrealistic striving (including the struggle to reverse or deny a routine burnout) as an important part of an overall strategy of "re-framing"--i.e. acquiring a new way of looking at things. In a "refresher" course, this module would normally emphasize self-awareness (of Achilles' heels, assets, unnecessary pressure, etc.) as a critical factor. Under suitable conditions such comprehension would lead naturally to challenging and letting go of energy-draining illusions, assumptions, expectations, injunctions ("musts"), and false cures. This approach often begins with close monitoring of scales measuring sources of stress, stage of burnout, and health hazard, followed by values clarification as well as life and career planning exercises and deliberate re-designing of health habits and overall lifestyle. "Survivors" have been found to be especially adept at quickly reading between the lines to determine the "hidden job structure" behind the official job description. Such detective work will usually restore much wasted energy.

Some occupational hazards put all but a privileged few at sufficient risk, according to Dr. Ray Wehner of Selkirk, Manitoba, to necessitate a structured burnout preparation plan for both individual and organization. At the 1982 Rural Conference he advocated the equivalent of a "fire safety and prevention program" that would better equip us to take precautions concerning obvious "fire hazards" and to manage the un-preventable fires (and their aftermath) with skill and confidence rather than panic and helplessness.

MODULE THREE: RE-NEGOTIATION SKILLS

Although her island community seems too close for comfort at times, Lazare provides hope for those who have wondered "What do you do for curtains when you live in a fishbowl?" She also gives some insight into the ways in which a small-town context can create tensions involving family and friends, personal identity, sense of responsibility, and guilt. Suggestions are included for: setting limits, resisting intrusions, establishing role boundaries, and getting away from it all ("escape hatches"). Barry Stein's paper, "Limit Setting", explores similar issues in Section Two of this Handbook.

A comprehensive module would include (as required) some skill-training with rehearsal in such critical related areas as: expressing criticism, making reasonable requests, refusing unreasonable ones, reaching workable compromises, and perhaps even pushing for reforms (working conditions, etc.). All this and more is covered in the better assertiveness books. Re-negotiation skills can be an essential tool in cutting back on excessive commitments (e.g. the "Charles Atlas Syndrome"). For those working with others in the same organization this module could be strengthened by including sessions on team-building or other forms of organizational development. Even without a new division of labour or other behavioural changes, stress can be reduced considerably by negotiating stress reductions in the physical office environment involving noise, smoke, interruptions, etc. Stress Action Groups (along the lines of the Quality Circle groups) are doing this and much more by mobilizing staff frustration and energy. Of course, such negotiation is too stressful in itself for those who are not personally replenishing themselves.

MODULE FOUR: RE-CONNECTING SKILLS

Miller and McSweeney reflect on the problems of inadequate peer and supervisory support, and other survival threats often associated with remote settings. Some of their suggestions include: more sensitive selection and orientation practices, regular contact with a rurally-oriented consultant, meetings of solo workers, etc. A major point was made of the need for a strong combination of supervisory, collegial, and private social supports. Sata's overview paper also includes much helpful material on making meaningful connections with those in the host community. Unfortunately this module will probably be too difficult for those beyond the initial stage of burnout since some of the major burnout symptoms include such relationship-threatening behaviours as: distancing, detachment, alienation, cynicism, suspicion, and hostility.

It seems that the strategy of building a reliable, nurturing social support network (including at least one very emotionally open friendship) is best applied either before social functioning is diminished or after some of the changes produced by any of the first three modules have greatly restored it. Those familiar with family systems work might profitably add a segment on "re-positioning" oneself in the family of origin to increase acceptance and support while decreasing "unfinished business" on the job. A major indication of success in "re-connecting" is the restoration of an optimal level of involvement with clients (detached concern). This point in the sequence is often quite suitable for strengthening the role of stroking, touching, and generally nurturing relationships.

Of course, these notes and the articles to which they relate are intended only as an introduction to this rapidly developing field since so much more will be available by the time this book is published. In the meantime, I have compiled a resource guide at the end of this section which summarizes enough additional materials to enable the concerned individual or group to plan an effective all-round renewal program. Others' needs may be satisfied by merely reading about what's available.

It would be useful to review the summaries of the modules and ask a few pointed questions: In which of the four module areas do you experience your most energy-draining stresses? Do your coping responses tend to be evenly divided among the four basic groups? How prepared are you to work on creating strengths in an area which seems underdeveloped? Conversely, are you willing to cut back in your over-use of a certain strategy if it becomes alienating to associates or otherwise self-defeating? When energy and emotional well-being are threatened, many people allow their areas of greatest strength and specialization to become so prominent that they eventually become liabilities, often contributing to burnout more than preventing it.

Another critical observation in the literature is that susceptibility to the health hazards presented in this section increases to the extent that an individual feels alone or cut off in his or her growing sense of weariness, disenchantment, etc. It is hoped that this entire section and the local discussions it inspires will help to lessen the power of such feelings, while strengthening the sense of connectedness among many of those who feel alone in their predicaments.

PERSONAL SURVIVAL ISSUES FOR THE RURAL MENTAL HEALTH WORKER*

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Introduction

When you find yourself a stranger in a community, it is understandable that feelings of isolation, loneliness and alienation may become a part of your reality. What is abundantly clear to me as a person of colour is that, while isolation may occur on the basis of being different, that is less a problem than those feelings which result from a sense of inadequacy, loneliness, lowered self-esteem and exclusion. As I reach into my past, I recall undertaking the responsibility of visiting 23 Latin American countries in 13 weeks, with only a rudimentary understanding of Spanish. As long as I could communicate in English, or used an interpreter, I had no problems. There were, however, many hours when I found myself alone in my inability to communicate, and I avoided potential encounters which might have turned out to be interesting or even fascinating adventures. As the weeks passed, I found myself increasingly confused and at times disoriented; then, by accident, I discovered while sitting in a park that Latin American children were more than willing to tolerate my atrocious Spanish. They demonstrated their patience and glee in being able to offer gentle assistance, and I began to improve my ability to communicate in Spanish. I eventually came to understand that my problem was self pride and that my narcissism interfered in my ability to communicate with others. It took children to teach me how infantile my behaviour must have appeared, and I was grateful for their willingness to help me in my own growth.

At other times in my life I've had opportunities to appreciate the beauty of solitude in being alone and not lonely. I gradually discovered ways of living and communicating with myself so that cabin fever or the hunger for human interaction did not overwhelm me. It is on the basis of these experiences that I desire to dialogue on the topic of personal survival. After all, those of us in the mental health fields - especially those in rural practice - are sometimes viewed as marginal by colleagues in our respective disciplines. In our work we are frequently solitary in dealing with the heavy burdens of our clients.

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Entry and Acceptance

The challenges confronting a newcomer who attempts to fit into a rural community contain ingredients worth identifying and illustrating by examples. Blending with the environment is a basic principle for survival in nature and certainly has equal applicability in promoting the acceptance of someone from the outside. If one ignores this principle, stereotypes are formed, since the individual becomes peculiar by his or her distinctiveness. Once responded to as a stereotype, the individual is then subjected to problems of overcoming this additional obstacle to acceptance. Approximately 20 years ago I tested this theory while spending several months in specialized training in upstate New York. I was curious and wanted to understand the diversity of populations in New York City. Each weekend I travelled with a pair of dungarees, a couple of old shirts and a sloppy sweater, and checked into small neighbourhood hotels in Harlem, in the Italian community, in the Puerto Rican community, and in Greenwich Village. Taking my cues from neighbourhood residents, I sat on curbstones, fireplugs, and door stoops, talking with people; and I not only discovered ready acceptance but also learned of their values, their cultures, their lifestyles, and their dreams. Since I wore no jewelry and the heels of my shoes were acceptably worn down, I not only survived these experiences but had enjoyment and learning in the process.

Two years ago, while consulting with Alaskan Eskimos, my typical mode of dress was a wool shirt, levis and boots; on numerous occasions I was misidentified, either as an Eskimo or as an Athpaskan Indian.

In that experience there was the added variable of attempting to bridge a culture known to me only through reading. The experience furthered my understanding of cultural clash between natives and whites, and the reciprocal but different stresses that such clashes generate for members of differing cultures. For myself I experienced both environmental and cultural influences from which important learning was derived. My previous trips to Alaska had been during winter months, so I had no prior experience with living in an environment in which there was no need for artificial light except between the hours of two to four in the morning. Long daylight hours had a peculiar personal effect on me which I later dicovered was not unusual for individuals in their first introduction to such an environment. To begin with, I found myself hyperenergized and interviewing people until one to two o'clock in the morning, with little awareness of the need for sleep. The behaviour which I was exhibiting, had it continued and escalated, might have been identified by the local inhabitants as the "summer crazies."

Another brief example: while visiting a fish camp located on the Kuskokwim River, I happened to notice a glitter at the water's edge. Upon closer examination I discovered a quarter-inch band of golden particles extending as far as my eyes could see. Instantaneously, I experienced gold fever and shouted to my Eskimo host my astounding discovery. His response to my shouting "My God -- isn't that gold?" was to wander over, politely peer over my shoulder and respond casually, "Yeh, I guess so" --

and then to return to drying his fishing nets. I could feel the pull to become a 79'er juxtaposed against the awareness of how important it was not to offend my host with the mannerisms of a exploitative outsider.

As important as blending into the environment is the need to communicate interest and understanding of those living within that setting. Again, I draw upon experiences from 15 years ago, when I spent summer months in northern Maine and discovered how difficult it was to initiate any conversations resembling genuine interpersonal human interaction. People of Maine are perhaps not too unlike rural Canadians, and tend to stay to themselves and communicate in monosyllables. When I made an effort to engage people in conversation by asking questions or making comments, I would frequently be met with a response of "yup" or "nope," but without significant engagement. One evening I wandered into the local library and came across historical documents relating to the Great Fire which apparently consumed much of that section of the country in 1923. I became interested in reading further and discovered that the existing communities grew out of the ashes of the Great Fire, and that fortunes and lives were lost in that catastrophic event. Several days later I happened to engage in another one-sided conversation with a local resident and casually asked if his family had been residents of the area before the Great Fire. A previously unresponsive but polite and distant person suddenly became animated and spontaneous; he began talking about his family and his neighbours as if to communicate to me that if I knew about the Great Fire, I must be all right. In an interesting sequel, the same individual invited me to the town meeting to introduce me as someone who was "one of us"; even though he recognized me as an outsider, he wanted to welcome me to his small community. All of this is to suggest that when strangers come together and one is a relative newcomer, the values of the resident must be appreciated and recognized as the first step towards reaching the individual.

Family Issues

Relocation of families into a new community is invariably characterized by varying degrees of stress. The extent to which the entire family unit participates in the decision of moving also determines the extent to which problems can be prevented at some subsequent point in time. While most of us preoccupy ourselves with anticipatory anxiety, the role of the family in the realignment of relationships and the strengthening of the family unit in such moves needs to be recognized.

The pressures on family members vary considerably with the functional roles that the individual family member occupies. Critical to any family's adaptive success is the degree to which individuals are flexible and accommodative. While normative expectations exist within every community, the variations from one family to another within that community are considerable and represent cultural pluralism rather than a monoculture. As mental health professionals trained in understanding and mitigating the effects of stress in the lives of others, we should acknowledge those same helping principles as an ongoing aspect of our daily lives; and we can learn from one another. While I think of myself as knowledgeable about human behaviour, my children frequently identify aspects of my imperfect self requiring examination or change. The process of opening communication and inviting discussion of new pressures impinging on a family because of a move further strengthens the linkages between members of the family and provides a critically important support system for each member.

Fatigue Issues

The fatigue of mental health workers on the front line results from stresses that drain emotions rather than physical reserves. After all, it has been established that physical exercise in and of itself can substantially reduce emotional fatigue. Disciplining one's body is probably as important as disciplining the mind to be totally available in the day-to-day requirements of our jobs. While I was athletic as a youngster, jogging has never been of interest to me; but I do apply some limits on the type and amounts of food I consume. I do, from time to time, sit-ups and push-ups, and try to remain reasonably active working on the house, etc. Occasionally, like many others, I have dabbled with auto-hypnosis, transcendental meditation, and yoga; and while I find each re-encounter stimulating, I also find it difficult to sustain myself in such activities. For many of us, work provides the major source of meaningful activity in the rendering of public services to individuals in need. While any of the aforementioned topics could be discussed at length and ought to be pursued by those of you who are so inclined, I would like to focus on issues of integrating fatigue-alleviating interventions with ongoing work activities in one's professional life.

First and foremost, none of use needs to do everything, no matter how important we think we are. It is when I take myself too seriously and find myself caught up in my own omnipotence that I get into trouble. If I can catch myself in time and laugh at me, the work turns itself around and stops appearing so ominous.

At the same time it is important to pay attention to networking - to find and develop a social web of support with other frontliners attending this conference or colleagues with whom you work.

On the other hand if you work alone, as I frequently do, you might consider a device I've found very helpful. I converse with friends, teachers, and colleagues whom I carry with me wherever I go. I try to identify who can advise, listen, or understand my feelings, and I recall past experiences and conversations. I jot notes to myself, sometimes pick up the phone and call someone I've not spoken with for years.

Visibility Issues

Most of us who undertake new projects become enthusiastic; when properly channeled, enthusiasm results in the involvement of those around you. Undertaking new projects underscores individual leadership as well as professional competence. Being competent and having special skills, however, may prove to be a double-edged sword, particularly if the need for demonstrating competence continues to drive the individual. There are several potential consequences of such behaviour. If you are competent, others may become overly reliant and expect more of you, and the burden is increased rather than lessened. In the event of failure, the fall from glory may feel like jumping from the top of Mt. Robson rather than reflecting humanness and human fallibility.

How then do we avoid such circumstances? If you begin feeling that too many demands are being placed upon you, you should ask the question "Have I put myself in this position?"

Programs and services have qualities which resemble not only people but plants. They require tilling and preparation of the soil, adequate sunshine and warmth, with sufficient water and nutrients to facilitate maturation and growth. For individuals charged with developing services, over-enthusiasm may lead to acceleration in growth and development that at some subsequent point in time falls apart because the roots are insufficiently grounded. It may be more appropriate to be in step with your community, to allow the community and its people to grow with you in order that those services developed will have a solid foundation of community support. Such a strategy places the individual in a position of primus inter pares rather than as a messiah or leader of the group. It helps to avoid over-reliance, over-dependency, and drawing negative attention to the individual as being "too radical," "too new fashioned," etc. Challenge yourself to use your interpersonal skills in making others who are members of your community the visible persons. After all, when the lime-light is shared it facilitates your acceptance, leads to the development of a support system and, most importantly, makes mental health issues as much their responsibility as yours.

Self Management of Stress

TABLE I

Job Stressors

- Fit with job assignment
- Role conflict
- Lack of authority
- Role ambiguity
- Interruptions
- Workload - qualitative and quantitative
- Supervision
- Peer relationships
- Relationships with other units
- Responsibility for others
- Evaluation

Table I is a partial listing of common stressors associated with work. While job stress varies from individual to individual, it correlates positively with social stress, coronary-prone behaviours, and poor emotional and physical health.

Personally identifying work-related stressors is an important step towards managing and decreasing job stress for the individual. Given sufficient specificity, this process helps in pinpointing etiologic factors and determining whether interventions should be directed at 1) the job, 2) relationships at work and/or 3) personal life. The assigned work role may be dysfunctional for the individual, in which case transfer or reassignment may be indicated. Relationships with superiors, subordinates and peers may be improved through discussion and negotiations. Techniques of self-management in the individual's personal life may reduce stress through, for example, exercise, dietary controls, and meditation.

When organizations themselves join workers in addressing stress reduction, some creative solutions are possible. For example, in some high-stress organizations an interesting employment model has been developed and briefly described as a four-two-four employment program. Two full-time-equivalent positions are occupied by three individuals, with each person working eight months per year on a four-months-on, two-months-off schedule. Such a system enables two of the three people to be available at all times, and gives each an opportunity to overlap with two different co-workers during each four-month period. The three individuals must of course be compatible; each must be willing to work for eight months per year; and all three must be committed to such a schedule. Full-time workers are also needed for continuity; but this rotation has proven to be an excellent arrangement for mothers with dependent children, individuals who enjoy travel, etc. Interestingly enough, those who participate in four-two-four programs tend to work harder; with a conscientious triad there is a lessened tendency for clients to drop between the cracks, and caseload transfer problems are minimal.

A variety of self-assessment scales exist in the growing literature on stress, and many examples are included within the appended suggested readings. Table II is a descriptive listing of conditions contributing to stress. It was developed by Charles Seashore, and provides both insight and strategies for possible modification by the individual.

TABLE II

Conditions and Strategies

1) Overload:	Too much stimulation, demand, or required energy - too much work - not enough time - unrealistic
2) Isolation:	out of touch - alienated - uninformed - lacking resources - feeling abandoned - lack of orientation to work - depersonalized
3) Stuck:	feeling trapped - boxed in - unrewarded - no place to go - on a treadmill - nothing on the horizon
4) Entangled:	restricted - each step heavy - obstacles to goals - too many people - red tape - not worth the effort
5) Bottled up:	no release valves - can't express feelings - fearful and threatened - excess baggage from the past - no point in trying to get others to understand
6) Bearingless:	hopelessly lost but right on time - lack of clear goals and priorities - not understanding how I fit in the big picture - no sense of how or what to contribute
7) Leaky boundaries:	vulnerable to being invaded by other person's needs, goals and priorities - too many people have access and make demands - scattered energy in trying to do too many things at the same time - feeling out of control - can't say no
8) Procrastination:	avoid dealing with stressors - allow pressure to build by mismanaging time - lack of discipline/ capacity to make and meet commitments to others
9) Double bind:	damned if you do and damned if you don't - conflicting demands and requests - to make progress means making trouble for one's self - too many masters
10) Greedy:	anything worth doing is worth doing to excess - want to do everything - got to take advantage of every opportunity - bottomless pit of needs and desires for things and experiences
11) Out of shape:	not caring for one's own body - easily fatigued - low energy level - overindulgence - poor health habits - abuse of substances - non-adaptive behaviour patterns, life style

These human conditions affect each of us from time to time, and some more than others. They represent patterns of behaviours which we have learned and become comfortable with, despite the fact that they are neither necessary nor impossible to alter.

As a simple illustration: when my behaviours around procrastinating interfere, my pattern includes the tendency to sharpen pencils, clean the desktop, sort old mail, bills, checks, etc. when faced with filing income tax returns. Were I to allow my patterns to control me, those activities could go on for several weeks. While the pattern remains unchanged, I have reduced the time I participate in that peculiar ritual so that the procrastinating behaviours now occupy 15 minutes or less. One way of managing an unproductive behavioural pattern is to accept our human failings and to treat such a pattern as if it's an accordion: compress rather than lengthen time devoted to non-productive behaviours that contribute to added stress in our lives.

There is a popular game in the United States called Dungeons and Dragons which allows individuals to tap their own creativity to overcome obstacles and create their own heroes. I mention it only to state that all of us have dungeons and dragons of our own creation residing within us. The reason they are frightening is that my dungeons and dragons are of my own making and were originally designed to frighten or constrain me. These images of old frequently awaken when I am stressed and increase my sense of insecurity, alienation and helplessness. The images appear gigantic if I allow myself to forget that when I originally created them I was a tiny tot and my dungeons and dragons revolved around adult figures who, indeed, appeared to be giants.

Many of us in adult life deal with these ghosts of past images as if they actually existed rather than taking them for what they are; we spend enormous time and energy fighting them. Since they always awaken at times when we need all our energy to address the stresses of new assignments, it is no wonder we end up with the sense of constant fatigue.

I doubt that I have spoken of things that are not known to each of you. What is different in this presentation is my attempt to use "I" statements to, in effect, "own up" to both my aspirations and shortcomings as a human being, and to share with colleagues some personal views and experiences. I am hopeful that the use of "I" rather than "you," "they," "we," becomes an established working norm during this very unusual conference that seeks to address personal as well as professional development. Lastly, it is my hope that you may even identify some of your unique dungeons and dragons, deal with them while engaging and sharing with others, and release them in Kelowna when you leave, to have them wander in the forests and mountains where they belong rather than carrying them home with you.

SUGGESTED READINGS

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CONTRIBUTIONS TO FATIGUE & RENEWAL: A PERSONAL ENQUIRY

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In researching this topic, I decided to raise one issue of critical significance to my fatigue and explore it in some depth: the matter of personal responsibility for avoiding fatigue. My presentation is in the form of a challenge to caregivers to examine the premise that we are often as fatigued by the stresses to which we subject ourselves as by the external demands of the job. First, I would like to say that fatigue is different from burnout. Burnout is a syndrome with which most of us are at least intellectually familiar. (See other chapters in this section.) Burnout seems to me to be a state at which we may well arrive if the less drastic state of chronic fatigue is not first recognized and dealt with effectively. Accordingly, my objectives are that by the time you have completed this chapter you will have developed for yourself a personally relevant and identifiable list of fatigue symptoms and that you will be better prepared to reverse this process whenever it seems to be going too far.

I hope you will be able to adopt some simple method of appraising your lifestyle that will quickly help you to decide when you do need to make adjustments that will be useful in reducing your daily stress load. Another aim is that you will use the following remarks to develop a plan for reducing the stress associated with suspected energy-depleting habits. My own contribution will be to provide questions and comments that may stimulate you to review the major areas of your lifestyle that would normally affect your fatigue level. My own recommendations for avoiding or remedying fatigue will typically be implied by my questions rather than stated directly.

I will be looking at four broad aspects of our functioning, using the "PIES" formula, i.e. Physical, Intellectual, Emotional and Spiritual dimensions of self (Tables I, II). In reviewing each of these aspects for myself, I have found it useful to ask myself rather searching questions that I have prepared in advance because it is too difficult to think of such questions each time (especially when I'm already tired). Although the questions have been developed as an early warning system for detecting the build-up of fatigue, they are also useful in gauging the depth and breadth of relaxation, since all four areas are involved in the full relaxation response.

Physical Relaxation and Renewal

When I am feeling tired it seems reasonable to start with an inventory of the physical realm. As I share my questions with you, you may benefit even more if you think of additional questions which reflect your special strengths and weaknesses.

- Am I getting enough sleep? Do I know the amount of sleep which is optimal for me? Do I get that amount regularly enough?

- Am I capable of inducing some form of waking relaxation response during the day? Have I been allowing myself to build up too much muscle tension in my hurry?

- Am I sure I am in good enough health? Have I had my annual medical examination yet?

- Have I been leaving time daily to engage in some form of vigorous satisfying exercise that keeps me fit and energetic?

- Am I within the recommended weight range for my age and height?

- Have I been eating regularly? Are my meals well-balanced, and have I been maintaining an adequate calorie intake? Are my nutritional requirements being met?

- Have I avoided loading my system with refined carbohydrates and other stimulants such as coffee, tea and cola? These all cause some fluctuation in blood sugar levels and certainly contribute to fatigue.

- How stress-free is my environment? Is it well-lighted, comfortable, well-ventilated and free of regular physical discomfort of any kind, including intrusive noise and constant interruption?

- How much have I been smoking, and what other pollutants have I been taking into my lungs?

- Can I honestly say that alcohol and its associated activity is not frequently a producer of fatigue? Watch out for this one! Studies show that frequent use of alcohol is definitely associated with a drop in interest in other activities, including work. Also increased intake is often one of the early signs of burnout.

- Am I trying to balance much heavy mental activity with a suitable amount of physical acitivity whenever I can, or have I become too sedentary?

- Have I set aside some time every day for doing something which I thoroughly enjoy? I often completely neglect my playful side when I get too caught up with work.

I would suggest that if the yeses are few and far between as you reflect upon these questions, you may already have some notions about why you are less energetic than you would like to be.

Intellectual Relaxation and Renewal

"As a man thinketh in his heart, so is he." This biblical proverb has been echoed countless times by Ellis (Rational Emotive Therapy) and in the Cognitive Therapy of Beck, Meichenbaum, Mahoney, etc. Negative thoughts and confusion cause stress and fatigue. Order and positive, purposeful thoughts free up energy. So I ask myself:

- Am I usually relatively methodical in organizing my time? Having made a schedule, do I stick to it, maintaining only reasonable flexibility?

- Do I regularly look at my obligations and responsibilities to myself and others?

- Have I made it a point to set personal, family, and work goals so that I can make sense of what I am doing most of the time, and be satisfied with the way I spend my time? In short, am I a decent planner and time manager?

- I have to look at the style of my thinking. I find that sometimes I am clear and goal-directed in my thinking and at other times vague and daydreaming and wandering, allowing many intrusive thoughts. I can become very tired and stressed just from my own style of thinking if I don't make a conscious effort to improve it. I much prefer thinking that is relatively positive, calm, clear, goal-oriented, free of punishing and judgmental content. Many think they have no control over the content and style of their thinking. However, this is not true and those who are stressing themselves with their own thoughts should really look further into any of the cognitive therapies.

- Do I know what stimulates me intellectually? Do I make a point of engaging in that activity regularly enough to meet my needs for challenge?

- Am I able to effectively avoid worrisome and morbid reflection, catastrophizing thoughts, and other self-defeating habits such as remorse, envy, and resentment?

- Am I willing and able to challenge my reality, i.e. my ideas, prejudices, etc. by a definite attempt to be open-minded and seek new information?

- Do I honestly believe that what I do is worthwhile and that my work is appreciated by others? Do I usually make my decisions on the basis of my own perceptions, even though I value the opinions of others? Do I regularly check my progress towards my goals and acknowledge and savour my accomplishments?

Emotional Relaxation and Renewal

Next I want to discuss stress caused by emotion. Many people are fine when alone, others are okay when with other people. Stress may come from both intra- and interpersonal sources. When you find yourself especially stressed and fatigued it may be that you are using up much valuable energy suppressing or otherwise contending with your more troublesome emotions as you go about your daily work. If you suspect this to be the case you might probe your emotional risk factors a little more deeply with questions such as these:

- Am I really free of fear? Before you say "Yes, I think I am," check these areas: There are often concerns about managing financially. Has self-reliance failed you and has that frightened you? Have you lost someone that you formerly depended on? Are there fears in the sexual area or for your health? The intrusion of words from T.V. and radio often makes us vaguely afraid as we hear of world events and current affairs that we can do nothing about. Do you worry when you hear of accidents and bad weather? Do you get anxious about injury to life and limb? About pollution? How about aging? Your competence? How about the fear of someone bringing to remembrance past humiliations or wrongdoing? Often fear is hardly recognizable until we sit quietly and think about the things that bother us throughout the day.

- How are my interpersonal relationships? Am I mostly free from uncontrollable anger and resentment towards any person, institution or authority, or am I sort of "burned-up" most of time? Am I relatively free of neurotic guilt over past wrongs or present activities? Can I really say that there is no chronic source of frustration in my life at this time that I have postponed coming to terms with? Are my relationships with my spouse, my children, my parents, my boss, my co-workers and significant others amiable most of the time or are there ongoing relationships that I should be taking real steps to mend?

- Am I chronically lonely or do I have a sense of belonging? Do I know where to go with confidence when I need understanding and support or just a listening ear, or do I feel I have to go it alone?

- Can I honestly say that I am usually comfortable in most relationships, and that I have no need to avoid responsibility through deceiving, manipulating or using similarly stressful tactics in getting along with other people?

- Is it relatively easy for me to live and let live, avoiding taking on troubles of others and struggling to provide solutions?

- Can I say "I don't know" without difficulty, or is anxiety about the embarrassment of revealing my fallibility draining my energy?

- Am I comfortably assertive in most situations, so that I can avoid the extremes of being taken advantage of and being aggressive and getting into fights?

- Do I have persons with whom I share enthusiasm and interests, both at work and socially?

- Can I translate the positive feelings I have for others into appropriate actions most of the time without feeling too inhibited?

- Can I comfortably receive the outreach and affection of others most of the time?

- How well do I recognize and take care of my need for balance between being with others and being alone?

Spiritual Relaxation and Renewal

Finally, I would like to talk about the spiritual aspect of fatigue.

Spiritual dis-ease contributes more to stress, I believe, than many people will ever acknowledge or realize. Persons who largely rely upon a benevolent Creator as the centre of their lives have daily access to the ultimate source of sustenance, purpose, and vitality. Those without a continuously re-generating centre to empower them may be vulnerable to an extra measure of fatigue. Of course spirituality and faith alone are not likely to reduce stress and improve your survival chances unless the element of trusting child-like confidence is central enough to ensure relevance to your daily life.

In this regard, I find that it is useful to ask myself from time to time questions like:

- Does my work still have spiritual meaning for me?

- To what extent have I been living on the basis of what I understand to be spiritual principles on a daily basis?

- Have I been making priority time in my daily routine for such renewing spiritual exercises such as self-examination, confession, praise, prayer, and meditation?

- How well do I embody forgiveness, restitution, and reconciliation? How consistent am I in being a healing influence in ailing relationships?

- To what extent am I part of a community of mutually supportive kindred spirits with whom I can express my spiritual beliefs?

Conclusion

Although putting ourselves under the spotlight in this way may require an uncomfortable amount of openness at times, the benefits of such responsibility-taking can be enormous as we become less fatigued and therefore less fatiguing as well. Of course, we will always be able to find those who will gladly collude with us if we are tempted to blame all our fatigue on our surroundings (not to mention the damn cussedness of people we have to work with) without first assessing the extent of our own self-defeating survival tactics. However, I thought it particularly important that we at least entertain the notion that maybe we aren't taking care of our personal survival as well as we could be, even though we are competent caregivers already.

In summary, our chances of surviving (and hopefully thriving) in a mental health career without succumbing to chronic fatigue depend a great deal on our willingness to monitor and modify our lifestyles and ways of taking care of ourselves. The public use us, rightly or wrongly, as strong persons from whom they can receive direction and nurturance. They do not expect to look after us, and those who employ us do not expect to look after us. If we don't look after us, no one will. We are "it" and so must assume the responsibility of caring for ourselves.

LIFESTYLE INVENTORY
Table I Energy Builders

Physical	Intellectual	Emotional	Spiritual

- meet sleep requirements
- keep regular hours
- avoid sedatives
- maintain balanced, regular diet
- ensure minimal use of:
- - caffeine; alcohol; concentrated carbohydrates; tobacco
 	
- exercise regularly
- avoid long, unbroken periods of sedentary activity
- maintain comfortable work environment:
  - good light
  - fresh air
  - low noise
  - organized work area
 	
- maintain relative freedom from intrusion
- attend to health maintenance
- get prompt medical attention for infection, pain, inhibited function
- go for yearly physical check
- meet requirements for tactile stimulation
- maintain optimistic outlook
	- set daily goals (work and personal); priorize, organize
	- carry tasks through to completion as often possible
	
	- vigorously maintain positive thought content re self and others
	- avoid blaming, self-pity, pessimism, ruminating on past mistakes
	
	- maintain realistic expectations re self, re others
	- regularly acknowledge successes
	
	- plan assertive action for problem solving
	  a) for identification
	  b) for step by step resolution
	
	- maintain open-mindedness and curiosity regarding learning
	- accept new challenges regularly
		- indentify sources of any tension, guilt, resentment, fear (and take early action to resolve)
		
		- arrange regular periods of muscle relaxation
		
		- be congruent in self-expression
		
		- quickly identify and work through conflict with others
		
		- engage in relaxing, enjoyable satisfying activites daily
			- develop and maintain a definite philosophy of life which includes reason for hope and optimism
			
			- balance independence and dependence on others in a healthy way
			- attend to needs of others
			- avoid extreme self-seeking
			
			- take time for regular companionship with kindred spirits
			- regularly engage in objective and honest
			  - self-examination
			  - open confession
			  - correction of wrongs done
			
			- behave in a way that is consistent
			- with personal philosophy or beliefs
			- make time for worship and other forms of creative self-expression and renewal

NOTE: These samples were developed for the author's personal use and are not meant to be prescriptive.

LIFESTYLE INVENTORY
Table II Energy Depletors

Physical	Intellectual	Emotional	Spiritual
- insufficient sleep - irregular hours - use of sedatives - abuse of alcohol - excessive use of stimulants - irregular diet - inadequate diet - heavy carbohydrate intake - overeating - smoking - inadequate exercise - sedentary lifestyle - poor work environment - inappropriate lighting - uncomfortable temperature - stale air - constant interruptions - high noise level - inadequate clothing Neglecting: infections chronic pain inhibited function	- negative thoughts - self-pity - catastrophizing - blaming - ruminating, i.e. past failure - resistance to optimism - undirected thought style - vague - intrusive - unrealistic - failure to identify problems accurately - failure to set goals - failure to organize - failure to priorize - failure to carry through on plans - failure to acknowledge success (or failure) - failure to find stimulation - boredom - "closed mind" - unimaginative - avoid challenge - avoid collaboration	- harbouring - guilt - resentment - fear - prolonged conflict with others - incongruent expression - loneliness - repression - withdrawal - excessive dependency - rigid independence - anger - jealousy, envy - immobility - habitual muscle tension	- confusion - lack of definite philosophy of life (reason to be) - self-centred thoughts - self-seeking behaviour (all areas of life) - neglect of - self-examination - open confession - correction of wrongs done - neglect of needs for - worship - self-expression - fellowship - intimacy - neglect of social relationships - family - friends - co-workers - neglect of legitimate obligations - behaviour incongruent with ideals - deliberate insincerity

NOTE: These samples were developed for the author's personal use and are not meant to be prescriptive.

LIFESTYLE INVENTORY
Table III Personal Habits to Modify

Physical	Intellectual	Emotional	Spiritual

THE PATH OF LEAST RESISTANCE: ISOLATION AND THE PARADOX OF BURNOUT MANAGEMENT

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This paper presents ways for the isolated mental health practitioner to deal with burnout. After defining terms, we will offer a model of the burnout cycle which includes the two major ways of handling it. The personal approach includes the use of paradox and other therapeutic strategies from General Systems Theory, Rational Emotive Therapy and Cognitive Behavior Therapy. The organizational approach focuses upon redesigning the job through Motivational Patterning.

The Problem

Who is the isolated mental health practitioner? You could qualify for membership in this group by being isolated from support systems. It could mean having a boss you rarely meet, seeing colleagues for brief stolen moments in the year, lacking immediately accessible referral sources, having difficulty getting away for a workshop, spending a lot of non-productive time travelling, being the only person in town who handles mental health, or many other factors. To one person, being far from a university library might hurt the most. Another would miss socializing with colleagues. In one study of new helping professionals, isolation from colleagues was strongly associated with negative career outcomes (Cherniss, 1980). Whatever the individual patterns, isolation worsens the already difficult problems in the mental health business. It is no wonder that isolated practitioners frequently describe themselves as burned out.

Defining Burnout

Burnout is an especially apt term when applied to a crisis in the career of isolated practitioners because the first recorded burnout victim to define his condition resembles them in so many ways. Dr. Herbert Freudenberger (1980) is a private psychologist who spent several months working 18-20 hour days because of a second full-time job as a therapist in a slum area free-clinic treating bad trips, etc. By the time his family convinced him to fly away with them for awhile, he was too exhausted to make the morning plane. He awoke three days later. This convinced him that something was terribly wrong. He named it burnout and defined it thus:

> "To deplete oneself. To exhaust one's physical and mental resources. To wear oneself out by excessively striving to reach some unrealistic expectation imposed by oneself or by the values of society."

Cherniss (1980), in his recent excellent book on burnout in the human services, further defines burnout as:

> "....loss of concern for the client and a tendency to treat the clients in a detached, mechanical fashion (Maslach, 1976). Other changes include increasing discouragement, pessimism, and fatalism about one's work; decline in motivation, and involvement in work; apathy; negativism; frequent irritability and anger with clients and colleagues; a tendency to rationalize failure by blaming the clients or the "system"; and resistance to change, growing rigidity, and loss of creativity."

One of our clients, a burned-out social worker, described having these thoughts during a difficult family therapy session: "So why tell me about these problems? I've heard them all before. Why should I give a damn about your stupid problems? What I am I doing listening to this drivel?"

Frank (1973) showed that commitment, zeal, faith, and positiveness on the part of the therapist are more important determinants of successful outcome than the particular treatments used. This suggests that the burned-out mental health worker is going to be greatly diminished in effectiveness no matter how much technical know-how is retained.

The Burnout Cycle

We define burnout as the final stage of a process we call the burnout cycle. Hans Selye's General Adaptation Syndrome (Selye, 1956, 1976), G.A.S., is a useful metaphor. The isolated practitioner goes through stages of psychological stress which parallel the physiological changes of Selye's model.

> Alarm Reaction: Shock and Counter Shock. The organism is damaged. The alarm reaction spreads throughout the whole organism. Defenses against further damage are erected. The sympathetic nervous system is activated.

The mental health practitioner arrives in the community and discovers the size of the job. After the shock and the panic wear off, the typical victim doggedly sets out to be continuously responsible for the mental well-being of every person in the community.

> Resistance Stage: The sympathetic nervous system remains aroused and the adrenal cortex enlarges in order to repair the original damage. Continuing irritation from the stressor is contained by local adapative responses, allowing most processes to

> return to normal. The organism goes on absorbing punishment, showing no outward signs of its toll.

The mental health practitioner settles down into a routine of struggle against time, distance, people, and things. He or she is typically on call 7 days a week. Clients include people of all ages with virtually every problem. The practitioner often struggles with uninformed administrators and others with vested interests who place obstacles in the way of service. This routine may persist for months or years. Meanwhile, the damage is contained by "local adaptive responses" such as running, alcohol use, complaining, and taking holidays.

> Exhaustion: Symptoms of the shock phase reappear. Local adaptive responses have worn out and the stress reaction is spreading throughout the organism. The sympathetic nervous system is depressed and the para-sympathetic is aroused. The adrenal cortex is activated. When it can no longer prop up the organism, death ensues.

The practitioner has struggled harder and harder. But the methods for dealing with stress which used to work are now failing to contain the damage. Stress is pervading the victim's whole life. Fatigue and depression occur, and spill over into week-ends and evenings. The victim feels as if "punched in" (on duty) 24 hours a day. Feelings of despair, defeat, and perhaps existential pain overtake the victim. The struggle eases as hope is lost. Soon apathy replaces combativeness. Finally the victim gives up, either physically or mentally quitting the job.

Burnout is analogous to the exhaustion stage of Selye's model. Exhaustion or burnout is caused by the struggle against obstacles in the resistance stage.

In Selye's G.A.S., resistance is quite necessary for survival. Stressors are inflicting direct damage on tissue that must be protected. In the burnout cycle, however, the resistance stage is optional, because damage is cognitively produced. Circumstances are often unnecessarily interpreted as requiring hostility and time urgency. These feelings alter body chemistry, which in turn damages the victim. What would happen if the victim interpreted circumstances differently and somehow managed to avoid struggling against time and people? Burnout would be averted.

"Yes, but," the victim usually responds, "I struggle to get problems solved. If I stop struggling they don't get solved." There is a trade-off here between quantity and quality. The practitioner who struggles may see more patients more often than the one who doesn't. But therapy from a rushed, harried, tense person has a different quality than from a patient, calm, relaxed one. Freudenberger (1980) believes that a primary effect of burnout is an inability to get close to people, and a good cure is to become closer to others. We believe that the quality of therapy would be so enhanced by a victim breaking out of the burnout cycle, that it would more than compensate for a decrease in quantity.

So, one means of dealing with burnout is to disrupt the resistance stage. This can be done by changing the victim and by changing the job.

Changing the Victim

In the literature, advice for inoculating oneself against burnout consists mainly of stress reduction techniques such as proper diet, sleep and exercise (Clark, 1980), meditation (Pelletier, 1977, Berkman, 1978), relaxation (Forbes, 1979), and positive thinking (Khalsa, 1978). But these recommendations too often only allow the victim to extend the duration of the resistance phase. One can struggle longer and harder with proper rest, nutrition, and vitality. If we teach a rat to relax while being injected with irritating chemicals, the stress reaction may be reduced. But this will only delay the onset of exhaustion. The mental health practitioner who continues to struggle against obstacles in a combative mode hasn't changed anything by giving up coffee. The rat would be better off learning how to escape the lab. The victim of burnout would better off ceasing the struggle.

We have used three approaches for inducing victims to stop participating in the resistance stage. The first is derived from General Systems Theory.

Reframing

Watzlawick, Weakland, and Fish, in their book, Change: Principles of Problem Formation and Problem Resolution, recommend second-order solutions to problems. The first-order ("more of the same") solution to being chased by a man with a knife in a nightmare is to run faster. This solution doesn't work and only delays the elegant second-order solution of waking up. However, the first-order reality of the dream does not contain information about dreaming versus waking; as a result, the actor in the dream can only decide to wake up by sensing a larger system of reality. Paradoxical methods of reasoning can allow such illumination. Often the problem is defined out of existence by the larger context.

In our first-order reality, burnout is only a failure which is to be avoided. But the very struggle to avoid failure is the resistance stage, burnout's precursor. As is so often the case, "more of same" first order solutions ("I will struggle harder") are standing in the way of an elegant second order solution ("I'll stop struggling and drop out of the burnout cycle"). How might a victim be induced to look at the cycle from a distance instead of from inside the nightmare that it is? Can the victim be snapped awake to the reality that struggle and burnout are unnecessary? We might say to a victim:

> "Go ahead and enjoy your struggle. It won't go on forever because the mental health care delivery system has automatic burnout. Burnout is one of the required stages of work. It's an obligation. The system expects periods of intense activity and

> productivity to be followed by periods of even more intense activity resulting in less productivity culminating in burnout, during which there is almost no activity and no productivity. Then you either leave the system and start a new burnout cycle in the shoe sales business, for instance, or you rest up during your burnout and start the cycle again in your original job. So, go ahead and burn out when you're ready. You have earned it and it's expected of you."

If somehow the victim can be convinced that burnout is something to be embraced and somehow enjoyed, the paradoxical effect is that the resistance stage is finished prematurely, and burnout is nipped in the bud. Or, by describing the burnout cycle as standard operating practice, perhaps we induce the victim to see the whole process from a distance, and decide not to co-operate. You decide to wake up out of a nightmare only when you succeed in realizing that it is in fact a nightmare and not reality. So we want to help the victim see how phony, artificial, and contrived the burnout cycle really is--how it's just another way that organizational life tricks us into working too hard and feeling bad. The validity of this observation was reported to us by a client from the mental health field who has experienced a terrific improvement in the quality of both his working life and private life since his burnout. He feels that it propelled him out of the cycle. But burnout frequently does not provide such a benevolent cure. Another client burned out in an administrative social service job, quit, and is presently burning out in a much more severe manner in a job that pays half as much. He has not broken out of the cycle.

Irrational Beliefs

Albert Ellis would have a lot to say to the burning-out isolated mental health practitioner. He would identify a vast number of irrational beliefs which were maintaining destructive illusions. One such illusion is that the resistance phase is necessary (Walen et al., 1980). It is fostered by beliefs and expectations such as the following:

> I should be treated fairly by the organization. They have no right to treat me poorly. Since they are my superiors they should make decisions which make matters better instead of worse. I can't stand another meeting. I have to serve anyone in the community who needs me. I must do my best to be all things to all patients. My patients ought to be grateful. I must succeed all the time. Everyone should like me. I should like all my patients. There must never be breakdowns in the delivery of services to patients.

Ellis would refute each irrational statement in hopes of banishing it from the victim's belief system. For instance, he might say, "Organizational life is never just and no law says it must be. So it would be rational to expect injustice in organizations and to be pleasantly suprised by the rare instance when justice is served."

Ellis would insist that we choose to struggle, and that we can break ourselves of destructive resistance-stage behaviours by monitoring our own decisions and beliefs.

At this point the victim protests that struggle is necessary for some of these reasons:

- If I don't, who will care for these people?
- If I don't, then I'll lose the job, lose the house, make my family suffer.
- If I don't, then how will I look anyone in the eye?
- I can't stop because the community won't let me, my employer won't let me, and my ethics won't let me.

Ellis would refute each rationalization in turn:

"You can't care for everyone, so inevitably some will have to get care elsewhere. You won't lose your job for cutting down to a reasonable work-week and if you did lose it for such a reason, then it would be good riddance. No one expects you to kill yourself, so your respect isn't lost. You can stop if you decide to. You can be almost as productive or maybe even more productive without struggling and without putting in so many hours and feeling so much hostility, pressure, urgency, and impatience."

Extinction of Struggling Behaviour and Thought

From a Cognitive/Behavioural point of view (Meichenbaum, 1977, Foreyt et al., 1978, Kendall et al., 1979), struggling in the resistance stage is defined as reinforcing merely because it exists. Firstly, the struggle is negatively reinforcing to the extent that the victim believes that the struggling is averting disaster (a false belief, since the struggle is actually hastening rather than preventing the onset of burnout). Secondly, the struggle may even be positively reinforcing to some extent. For instance, it may be somehow gratifying to be a martyr, especially if you fancy yourself a self-sacrificing tragic hero. In addition, there may be sources of social reinforcement for burning-out behaviour. Have we not been taught that giving up is bad, and that being a hard charger is good?

Colleagues, as a gesture of good will, could modify the behaviour of a burnout victim by giving social reinforcement to behaviours incompatible with the burnout cycle. A reduction in over-commitment through the timely use of "No" could be fostered on the job. More loafing and goofing off (e.g. fishing) could be encouraged for leisure time. Of course, co-workers might also help extinguish struggling behaviour by ignoring it (time out) or even criticizing it (punishment). However, we must take into account the fact that the burnout victim who feels isolated is left with the prospect of modifying his or her own behaviour, a task that can often be as futile as pulling yourself up by your own bootstraps.

Another way to extinguish struggling behaviour would be to show that the negative consequences far outweigh the positive ones. The discovery of the link between cancer and smoking didn't instantly extinguish all smoking behaviour, but it was the first good reason to stop. Millions of ex-smokers did succeed in modifying their behaviour primarily because of this one bit of information about a long-range health hazard. The risks of energy-draining struggling are no less sobering. One excellent reason to stop struggling is the proof that this behaviour causes heart disease and increases the probability of early death.

Type "A" or coronary-prone behaviour is essentially a struggle against time and people. Free-floating hostility is also a constant theme. The Type "A" person takes on more and more work. At Lockheed Corp., Friedman (1974) identified Type "A"s by speech patterns. People were assigned to the "A" group if they exhibited rapid, staccato-like speech, and interrupted often. Coronary heart disease (CHD) and CHD-related death were associated with this behaviour. Type "A" behaviour has been shown to be a powerful predictor of coronary heart disease (Rosenman et al., 1975). Severe Type "A" behaviour is associated with more severe and more frequent CHD (Zyzanski, 1977). Prospective longitudinal studies have supported these conclusions (Hayne, Feinlab, Kennel, 1980; Roseman et al., 1975). People who have survived their first heart attack can improve the probability of avoiding a second by changing their behaviour in the direction of Type "B" (Friedman, 1978, 1979). CHD is the principal cause of death to North Americans over 35 (Deszca et al., 1981).

Is the isolated practitioner any more likely to engage in Type "A" behaviour, and become vulnerable to CHD in the process? Let us look first at free-floating hostility, so tragically common among CHD victims.

Administrators are far away in a city culture. Communication breakdowns are inevitable, and guaranteed to exasperate the most even-tempered mental health worker. Here are excerpts from an exchange of memos between a rural mental health centre Psychologist, and a regional Programme Director. The Psychologist begins by saying, in part:

> "...The 'burnout', or (for us outside the city), the 'bush/cabin fever' is a serious and real problem. The best prevention against it is periodic contact with other professionals, preferably by attendance at educational functions, and the feeling that someone 'up there' in headquarters does give a damn about us, does appreciate our efforts, and does go to bat for us. None of the above seems to be the case now. How are we to fulfill our mandate -- a commitment to the delivery of highest possible level of service to our clients -- when we are getting more and more demoralized, isolated...and rusty in our clinical professional skills?"

The Director concludes his response with this paragraph:

> "As professionals, hopefully, one's education is not limited to initial professional training or conference attendance. With proper data collection and feedback mechanisms (even individually initiated) one's practice should be an educational experience. Further, scientific findings of consequence show up in the professional literature and for most persons keeping up with one or two core journals can go a long way towards the prevention of staleness. None of this is to argue against course or conference attendance, but merely indicates that there are some alternatives which are a bit less expensive and still relatively available to most of our staff."

Incidentally, these are not leaked memos. They were distributed all over the province by both authors, each secure in the belief that his memo was reasonable. Several isolated mental health workers responded to this memo the same way:

> "This is a 'Let them eat cake' response and worse. He is intimating that the Psychologist doesn't already keep up with the literature, a most dreadful insult to his professionalism."

Another isolated mental health professional stated: "The Mandarins in headquarters are more of a burnout problem than any local work situation."

Certainly this Director did not intend to insult the complaining Psychologist. Probably he was sincerely hoping to be helpful, offering fatherly advice. But mental health workers all over the province have talked about how insulting the memo was to them. Hostilities were still being stirred up months after it was written. Variations on this theme guarantee that the isolated mental health practitioner will have plenty of excuses to remain in a state of free-floating hostility. Resentment towards senior management is virtually a common denominator in all organizations, but isolation makes it even worse.

Distance is time and most distance-created problems become time problems. Time wasted travelling to a meeting will be repaid (with interest) upon return to the community. Caseloads grow and grow, putting more and more time-pressure on the prospective victim, because referrals are usually impossible. At the same time the community keeps presenting new things for the practitioner to do; and often the practitioner says yes because it feels good to be in such demand and to be held in such high esteem, or because the problem is just too heartbreaking to ignore. The result is a classic Type "A" pattern of more and more to do in less and less time.

Mental health workers as a group are pathologically high in Type "A" behaviour. The proof of this is immediate to the eye at any gathering of those in the profession. Our most mellow and relaxed colleagues would scarcely qualify as Type "B"s. And the isolated mental health practitioner is being subjected to conditions certain to bring out all the Type "A" behaviour that is possible.

We conclude that the long-term consequences of the practitioner's struggle are much more important and deadly than a brief bout of burnout. We see burnout as an adaptive response to a pathological state of affairs. We applaud the appearance of burnout as a sign that the destructive resistance struggle is coming to a head, and hopefully to an end.

Changing the Job

Now that we have discussed techniques for changing the victim's approach to the job, let us move on to the more obvious set of solutions to problem of burnout: modifying the job itself. Rural mental health practitioners cannot be all things to all people, but this seems to be the expectation placed upon them by the needs of the community. Despite narrow training in discrete specialisations, they are immediately swamped with work which seems to require specialised expertise in just about everything. Cherniss (1980) has shown that this factor is a primary determinant of burnout. The isolated practitioner cannot remain a specialist in one narrow area such as learning disabilities or marital problems or schizophrenia. It will be necessary to become much more of a generalist. If this is done with planning and forethought, then the process can proceed in an orderly manner and stress can be reduced substantially.

Typically, the new practitioner in town allows the community to dictate the terms of treatment. That is, the most squeaky wheels receive attention and the quality of the therapist's practice is tilted in the direction of these problems. But of course, there are quieter problems being experienced in the community that deserve the therapist's attention just as much, and here lies a possible solution.

According to Freudenberg (1980) burned-out professionals are spending all their time doing things for others, and doing what they think others require of them, until finally they "...lose sight of their own motivating forces and supplant them almost entirely by duties from outside themselves." For instance, you may have gone into Clinical Psychology (or another specialty) because of a fond interest in the treatment of alcoholics and drug addicts. This was your specialty. You did your thesis on the topic and published a paper that you are still proud of. And in your present small town practice, you light up on the two occasions per month that you deal with an alcoholic. The problem is that the other 95% of your patients are not playing to your strong suits. Your own favourite things, the work that gives you a battery recharge instead of a loss, is replaced by cases made more difficult because you were never really trained to treat them.

Motivational Patterning

It is clear that you must generalize. You must develop in a number of areas the kind of interest and expertise that you have experienced naturally dealing with alcoholics. The same characteristics of alcoholism that attracted you and held your interest also exist in a number of other areas of psychotherapy. So, instead of training yourself to deal with the noisiest or most adamant mental health problems in the community, train yourself to become an expert in a number of areas related to your first love.

Margaret Anstin (1980) recommends a technique called "Motivational Patterning." The point of this exercise is to identify themes which persist throughout all or most of the best experiences you have ever had, the most satisfying and rewarding experiences. It is a sort of projective test which reveals themes which can be generalized to other areas of endeavour.

Suppose that one recurring theme in all of the examples you could imagine was dealing with habits. Your best victories, and your most satisfying clinical cases all involved helping people break bad habits like alcohol addiction and drug addiction. This theme would point to other areas where you could seek specialized skills. You might find it rewarding to work with obese patients, smokers, people who hit their children, insomniacs, phobics. You might build a practice in the community that primarily addressed itself to changing "bad" behaviours, thus utilizing your own favourite modes of operation.

Of course, rural mental health practitioners are already doing their best to play as much as possible to their strong suits. But we have found that motivational patterning exercises can reveal strong suits that were previously ignored.

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CRITICAL ISSUES FOR THE SOLO MENTAL HEALTH WORKER

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We are writing as solo workers, practicing in remote settings in British Columbia -- one in the rural interior and the other in a small coastal village. Like most rural mental health staff, we share the dual pressure of responsibility for direct mental health services to an entire community and the mixed blessing of minimal supervisory back-up.

It is clear that selection of a suitable person to fulfil a solo mental health worker role is crucial. It is vital that both the organization and the individual be aware of the extent of his or her capacity to be effective in a position which lacks the colleague support usually found in team settings. It is the responsibility of the organization to ensure that there is a very full orientation to the new community and its specialized work setting. When a solo worker is placed in a community that has never had the benefit of mental health services, and is given primary responsibility for setting up the whole program, then a maximum of support should come from the sponsoring organization. Furthermore, the development of such a program should be monitored regularly to ensure that it is not only responsive to community need but also is known and supported by the organization providing the staffing.

In replacing staff from small or isolated settings, there is great value in providing considerable overlap for the new worker with the departing worker. Also, job descriptions could usually be far more helpful by covering much more of the real world of the individual mental health worker.

Solo workers must be comfortable with their own levels of competence, as they must establish credibility not only with clients but with other agencies and professional workers in the community. They must be able to function with a certain degree of serenity and enthusiasm despite a minimum of positive input and stimulation from colleagues. Making contacts with people working in other agencies in the area will help to avoid the sense of isolation produced by the inevitable coffee and lunch breaks without the companionship of co-workers.

Among the often overlooked qualities that are most essential if the solo worker is to be really effective are an ability to make one's needs known and the tenacity to persist when central office does not attach sufficient importance to one's requests. The needs of a program with a small staff, in a small community, are often not given very high priority when they are reviewed centrally together with the demands of large and vocal communities or programs. The easily-frustrated or quick-to-give-up staff member operates poorly in the solo setting and usually becomes antagonistic to the system and bogged down by trying to carry too much with too little.

It is clear that there are a number of different approaches to providing support for solo mental health workers in sparsely staffed communities. In some provinces there is a very specific schedule of visits made routinely by supervisory staff who meet on a planned basis with them. In other areas, the solo worker has been given the responsibility of initiating contacts with senior staff of adjacent centres only when there is a perceived need to confer. The looseness of some of these arrangements has left workers in some areas feeling alienated; they may find that their colleagues in nearby centres are not very aware of the circumstances in their community and are really not too helpful in providing the necessary support when asked.

In order to have an effective solo program, it is important that the consultants also be rather special people who have the skill to provide support services that are known to be helpful and appropriate to the needs of each community and worker. One of the most useful assets for such a consultant would be experience in comparable (preferably single staff) settings. Another way of handling the supervisory role would be to have a single consultant with the central office who would be responsible for the solo and very small rural centres as somewhat of a specialty, so that there would be a direct link to the central office through a consultant who was in close touch with the unique problems of the small centres.

In view of the lack of colleague contact, it would be useful to provide solo workers with increased opportunities to meet as a group specifically for the discussion of their common problems. This is considered essential by almost all rural workers. The resulting stimulation and exchange of ideas would enrich all the programs. There is great enthusiasm about the fact that rural mental health conferences are being held. However, many rural staff are disappointed that, because of restraint policies, only a handful of line workers can attend these conferences when they are held outside their own province.

The most vital concern of solo mental health workers seems to be the establishment of support systems that are meaningful. Most people working in the solo centres enjoy considerable freedom and feel confident that they are providing quality programs to their communities. But while independence is enjoyed, isolation is not. There must be a feeling that one is attached to an overall program with methods and goals that take into consideration individual communities and situations. At present, much of the support system must be developed by the individual working in the solo setting. This includes maintaining professional ties even if at a distance, and ensuring that there are satisfactory personal-social contacts that provide enjoyable leisure. In order to complete the picture, however, it is necessary that agencies and provincial departments provide adequate consultation services and supervisory staff. To improve the situation at all, these services will have to impart useful information and give a feeling to the solo workers that their contributions are understood and appreciated just as much as contributions from more centrally located staff.

VIEW FROM A FISHBOWL:

Some Implications of Practising and Living in an Isolated Community

Sharon Lazare, M.A.
Hornby Island, B.C.

This paper focuses on the problems (and "perks") of practising as a mental health professional on a small island or similar "fishbowl" environment. In such a remote setting, a goal of the mental health worker is to achieve a comfortable balance between social reclusiveness and full integration of the private and public aspects of life. The degree to which the mental health worker can achieve this balance will determine his or her ability to practice and thrive in a small isolated community. In order to convey a sense of what it is like to struggle with related problems and possibilities, several excerpts from conversations with island clients have been included.

Background Information

The reference community is an island whose population fluctuates from approximately 800 in the winter to 4000 in summer. It is relatively isolated in the sense of both difficulty of access (three ferries are required from the mainland of B.C.) and limitation of access -- the last ferry leaves for the island at 6 p.m. The author has lived and practised as a mental health professional on this island for the past three years.

Problems

The first problem I wish to present is the "no escape" one. In contrast to most urban situations, one confronts constantly one's successes and one's failures. There is no such thing as "closing the door" or "closing the file" -- unless of course clients leave the island. This can be a problem for the client too, as is indicated in the first excerpt:

> Client: Sometimes when I see you I have an instant flash of insecurity, when I want to turn around and run. It's not something that would last very long -- like when I would see you at the store I would want to turn around and run.

As you will note throughout this discussion, many of the concerns for the therapist and client are not unique to their kind of relationship. In general it is difficult for anyone to hide out when living in a fishbowl.

The second problem I wish to discuss has to do with role conflict. I am defining a role as a set of behaviours guided by one's self-perception at any given time. One's self-perception is largely a function of perceived expectations of others. When these expectations call for different responses simultaneously, role conflict arises. For example, when I ask someone at a party "How are you?" and the person stares at me hesitantly, I believe he or she may be wondering whether to answer as a friend or as a client, and the answer could vary accordingly. Though I may be clear about my role as "friend" at a given time, they may not be. (Incidentally, I no longer ask this question at parties.)

Throughout this discussion on role-conflict, I have implied that, for me, what happens, "in therapy" and "in friendship" are different. As we all know, there is today a big push toward self-help in the mental health field. Whether the motive has been partly political, as in the feminist movement, or philosophical, as in the anti-psychiatry movement, the goal has been to demystify the therapeutic process and make counselling skills available to the lay public. Nevertheless, it is generally recognized that there are qualitative differences between the interaction that occurs in a helping relationship and the interaction involved in a purely social interchange. What are the differences? I should like to illustrate this by presenting an excerpt of an interview done with a couple living on the next island:

Therapist: Why did you choose at this time to come to see me?

Client #1: There are certain impasses that I come to where there are a lot of unanswered questions; and I see that the people around me who are really close have the same unanswered questions. They are stuck at the same place. I think someone who has a lot of practice in these situations and can ask the appropriate questions might unleash something for me.

Client #2: I feel I can come to somebody like you on a continuing basis with a continuity of thought pattern from week to week; whereas with my next door neighbour and friends that we already do problem-solving with, it's somehow different -- you don't have the same ease in stepping back and picking up from what happened last week. I have never come for help to anyone else other than my friends, so it's totally new to me; but what I expect is that what happens this week we'll pick up on next week. I think that's possible in this kind of situation with you, and less possible with friends because so much happens in between.

Client #1: It feels more structured. It's a set-aside block of time, whereas with our neighbourhood relationships it's a matter of when you happen to see each other. There might be two-week gaps or a month-long gap between actually talking about personal problems.

Client #2: We do in fact get together with our friends once a week to do problem-solving, but on those occasions we deal with more individual personal problems rather than couple issues. I am happy to see somebody who has a little bit more professional background.

This couple already belong to a self-help group, yet at this point they feel the need for "professional help," which they are defining as more structured and somehow "deeper" than what is currently happening in their other group.

I then asked them how they would feel if I socialized with them, and here is their response:

Client: For me one of the advantages of coming to see you here is the separation that exists between us, whereas I am a little tired of having pre-judgements made about me by people who know me really well. There is a great deal of subjectivity in the decisions that people make about me and the advice they give, and I think that's really positive, but what we don't get is objective assessment by someone who is not attached to us. That's desirable for me right now.

What happens when this separation does not occur, such as when we do find ourselves socializing with clients? There are certainly advantages for the client: trust and empathy develop more quickly and (theoretically at least) the therapeutic process is shortened. I would like to demonstrate this with an excerpt from a client with whom we have socialized. The following excerpt will demonstrate the advantages for Annie of our multi-faceted relationships.

Therapist: Would it be easier for you sometimes to bring problems to me -- to see me as a therapist -- if you didn't know me as a friend? For you is it an advantage or disadvantage to live on this same island?

Client: Someone once said to me, "Why go to a therapist?" You are only listening to their point of view so why do that?" I think if I didn't know you I wouldn't care for your point of view. It's easier for me because I know you and I see the way that you live and I like your lifestyle. So, I don't feel you are going to tell me something that's not true -- I feel comfortable with you and your lifestyle and your surroundings, so it's easier for me in that sense to come.

In addition to the increased validity which Annie experiences by having as a therapist a fellow community member, she finds that her relationship with her husband benefits:

Client: My coming to see you has positive spin-offs in my relationship with my husband. If I went to a counsellor that I didn't know in town, he would not have anything to do with them. So that part of our lives would be totally mine and not his. On the island we often talked to you together, and so it is much more of a group thing (rather than "me versus him"), which I think is important. It would be much harder for me to explain to him what a counsellor had said if he was not there or he didn't

> know the person. He wouldn't be comfortable with this if he didn't know you, and he wouldn't believe that you weren't going to mess me up or tell me a lot of things that wouldn't fit in with how I live.

Having one person to whom one relates play many roles can increase the integration in one's life and can lead to a reduction in stress for that person. For example, what if your boss were also your therapist and you were, say, suffering from an ulcer? Your boss might be reluctant to push you to meet deadlines and work overtime. This very situation occurred on the island when we employed as a carpenter one of my physician husband's patients who suffered from ulcerative colitis. While we were impatient with the numerous delays, we were reluctant to push him too hard for fear of causing a flare-up of his colitis. As a result of this overlap of roles, we have here a situation which is potentially stress-inducing for the therapist (in this case the employer) and stress-reducing for the client (the worker).

One problem the patient experiences because of the closeness of the helping/social relationship is a concern with guilt for "overburdening" the therapist. As an example, we were once treated to a magnificent dinner by a couple who were grateful for help received when they had marital difficulties. At a later time, I asked the husband, who had come over for a social occasion, whether he would see me again in the future if he were having difficulties and he replied, "No, I wouldn't, it's your turn now."

Annie expresses the same concern:

Client: Sometimes I feel like I use you because I feel that I only come and see you when I am all messed up and that's not fair to you...

Thus on the one hand there is an appreciation of the closeness resulting from shared beliefs and values, and on the other a feeling of guilt about "using" me.

Another complication of the professional-social interface has to do with the delicate subject of self-esteem. To what extent do island people feel reluctant to see a local therapist because they are or are not friends; because they are or are not aware of a therapist living on the island; or because they are not willing to self-disclose? It is easy to fall into Irrational Belief Traps (Ellis) over such issues, e.g. "They are not coming to see me because they do not love me." I asked Annie about this and her reply follows:

Client: Certain people are much more comfortable with seeking help in town (or anywhere they're not known) because they don't want to admit or to be open about it. Also some people may feel threatened by your lifestyle and may feel it's not for them. I had someone tell me the reason they didn't come to you was that they didn't feel that your views on monogamy were the same as theirs, which at that time I questioned by asking them whether it mattered. You're not here to say "here's the way I am and here's the way you have to be".

Therapist: Maybe for them there was some fear that I would impose my value system.

Client: So I wondered where they would go, would they interview someone to find out whether their value systems corresponded? That's not very likely. I think a lot of people here don't see anyone at all or they go for something that's happening elsewhere....Also, I think people here get into a space of enjoying being miserable. It is very accepted on this island to feel low and people will pat you on the back and say, "I understand."

Therapist: Yes, and people get strokes and they cope with it that way.

So we have here a problem resulting from practising and living in the same place. The problem relates to one shared by many mental health workers -- that of isolation and lack of feedback.

In summary, then, some of the most problematic features of mental health work in isolated settings are:

1. The problem of complete visibility: how does one escape or at least hide when living in a fishbowl? Of course, such threats to privacy pose problems for client and care-giver alike.
2. The problem of role conflict: How does one choose at any given moment the appropriate response or set of behaviours? As an example, how does one socialize at a party without becoming involved in a therapeutic encounter? There are qualitative and subtle differences between friendship and therapy. Here again, clients were found to be no less affected by the problem than caregivers.
3. The problem of self-esteem: how does one cope with the wishes of people to seek a therapist further away? Also, how does one get enough contact and feedback from colleagues?

Solutions

1. With regard to visibility-privacy problems, reliable escape hatches are essential; the obvious solution is to take excursions away from the island or the region. Although there are hideouts on the island, our house is unfortunately in a spot which makes us very vulnerable to drop-ins. However, in terms of preventing a preoccupation with escape, I have found a notice board advising people about convenient times to be the more practical solution, since it almost guarantees effortless privacy.

2. With regard to the problem of role conflict, it would be helpful to have a separate space other than home where I could see clients. This work space would define the situations more clearly.

   I am also realizing that it is easier to see people in therapy whom I do not also see socially. Clients from the next island are ideal, since lifestyles and values are similar and yet we do not meet each other constantly. In fact, we mix intimately with very few people on the island; our close friends live elsewhere. Furthermore, solutions such as these inevitably bring about welcome spin-offs such as reducing visibility-privacy problems (#1).

3. Concerning the self-esteem issue, awareness of the reasons why island people do not seek local therapists has been helpful. I also believe that working even more closely with colleagues at the nearest mental health centre off the island to obtain the back-up, etc., will be very encouraging. A final ingredient of critical importance to flourishing in such settings is having intimate energizing friendships outside the "fishbowl" where you live and work.

Summary

In order to achieve credibility as a therapist in a small community, one must maintain one's identity as an involved community member. In order to practise effectively as a therapist, one must during working hours attain a separate and objective stance. Balancing these two roles has been the major concern of this paper.

The problems and solutions presented above are not unique to rural mental health workers, and each therapist must personally resolve issues such as self-disclosure, accessibility, and role definition. Reflecting upon the nature and intensity of the social-professional interaction helps to highlight some of these issues for all therapists.

GOING BEYOND PERSONAL SURVIVAL:

A Catalogue of Antidotes to Hard Labour and Burnout

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The following is a very personal selection of materials suitable for use as ingredients in a versatile modular curriculum by both individuals and groups. If the staff in a region happened to gain access to even one of the books in each of the categories in this annotated bibliography, they would have more than enough information for developing a long-range stress reduction and wellness program.

There are many healthy people who ignore with impunity even the more significant components of a prevention or recovery plan. Getting in top physical condition, mastering the relaxation response, having a resilient philosophy of life, or having another exceptional source of energy and well-being can be enough to get many people through. However, since we are known to be in such a high-risk line of work, we may need to get in better overall shape than many other groups if we wish to be ready for whatever additional pressures we experience.

MODULE ONE
REPLENISHING: Towards energy, health and vitality

A. On Treating the Body Well

Ardell, D.B. High Level Wellness. Bantam, 1979.
Holistic health approach comprising five segments on individual strategies. Several fresh ideas in the stress management section. Annotated bibliography (70pp.) devotes considerable space to balanced critiquing of health-promoting books.

Cooper, K.H. The New Aerobics. Evans, 1970.
Exercise strategies to get the blood pumping to the brain and extremities (e.g. swimming, jogging, bicycling, brisk walking).

Glasser, William. Positive Addiction. Harper & Row, 1976.
Clearly describes the rewards of jogging, meditation, etc. and a wellness-oriented lifestyle and how to cultivate an addiction to such things. May not be sufficiently practical for some.

Lalonde, M.A. New Perspective on the Health of Canadians. Govt. of Canada, 1974.
Regarded by many in health promotion in U.S.A. as the most respected and influential such document ever.

McCamy J.C. & Presley, J. Human Life Styling. Harper, 1975.
Holistic approach emphasizing nutrition more than other strategies.

B. On Letting Go of Tension and Slowing Down

Benson, H. The Relaxation Response. Morrow, 1975.
Medical account of benefits of TM and other physiologically powerful variants.

Colligan, D. Creative Insomnia. McGraw-Hill, 1978.
Comprehensive sleep improvement approach including "unwinding" (Jacobson's Relaxation).

Davis, M., Eschelman, E.R., & McKay, Matthew. The Relaxation and Stress Reduction Workbook. New Harbinger, 1980. 624-43rd Richmond, CA, 94805. Excellent multi-modal workbook using a dozen techniques including variety of forms of coping skills training besides relaxation.

Mason, L.J. Guide to Stress Reduction. Peace Press, 1980.
Practical, conversational. Whole range of relaxing techniques covered: includes thorough instructions for conducting five-session workshop.

Woolfolk, R.L. & Richardson, F.C. Stress, Sanity, and Survival. Signet, 1979. Traditional relaxation plus meditation and autosuggestion. Includes a dozen clear guidelines for a stress-free philosophy of living. Heavily influenced by Ellis (Rational Emotive Therapy).

C. On Getting a Charge Out of Life

Hansel, T. When I Relax I Feel Guilty. Cook, 1979.
Best source on daily mini-vacations and children as (potentially) great modellers of an energizing, satisfying lifestyle. Christian orientation.

Keen, S. What to Do When You're Bored and Blue. Wideview, 1981.
Much more substantial than the title suggests. Thoroughly researched and engagingly presented despite too many catchy aphorisms. Clearly distinguishes boredom from depression and apathy. Details the emotional spiral back from exhaustion and burnout or tedium and depression. Integrates psychological research with Zen orientation.

NOTE: Each of the above takes a high view of the human spirit, the mind-body connection and such child-like abilities as: fascination; total immersion in each activity; imagination; spontaneous artistic expression; "flowing" concentration; delight in little things; bouncing back from setbacks; emotional openness; "beginner's-mind", etc.

D. On Combining All Three Approaches

Adams, J.D. Understanding and Managing Stress. University Assoc., 1980. Most thoroughly prepared and tested. Widely used. Very clear. Includes workbook, readings and facilitators guide. See Module III, Holistic Living. Ordering details at end of this paper.

Neidhardt, J., Weinstein, M.S. & Conry, R.F. Stress Management Series. Western Center Health Group 1982. Based on much research and field-testing. See Modules entitled General Health and Well-Being (II), Quieting (V), Autogenic Methods (VI) and Progressive Relaxation Training (VII). Ordering details at end of this paper.

Tessier, N. Contributions to Fatigue and Renewal. Personal Survival Issues: Module One (this volume). Comprehensive self-help questions and guidelines for maintaining wellness in four major dimensions: physical, intellectual, emotional, spiritual. By a veteran Central Manitoba solo worker who has been involved with a strong team and mutual support network for many years.

MODULE TWO

RE-STRUCTURING: Towards realistic thinking, perspective, and planning

A. On Understanding and Managing Stress

Adams, J.D. Understanding and Managing Stress. Module One. Thorough but concise and practical workbook approach. May be best available for training, workshops, etc.

Albrecht, K. Stress and the Manager. Prentice-Hall, 1979. Amasses tremendous variety of interesting data leading up to a sound plan for "Redesigning Your Lifestyle." Emphasizes the synergistic (multiplier) effect of practising "the wellness triad" including relaxation, exercise, and sensible diet (R.E.D.). Good section on "encounter stress" and "contact overload." Great reference book for training program. The last chapter, "What Top Management Can Do About Stress" (35pp.), would be a good avenue of getting interested senior staff involved in reducing organizational health (and burnout) hazards.

Friedman, M., & Rosenman, R.H. Type A Behaviour and Your Heart. Knopf, 1974. The cardiologists who popularised the syndrome present causes and ways of minimizing unproductive life-threatening "hurry sickness".

McKay, M., Davis, M. & Fanning, P. Thoughts and Feelings: The Art of Cognitive Stress Intervention. New Harbinger, 1981. Supplements "The Relaxation and Stress Reduction Workbook" (Davis et al. above) with another dozen established techniques in the same effective workbook style. (Available: 624-43rd St., Richmond, CA, 94805.)

McQuade W. & Aikman, A. Stress. Bantam, 1975.
Links each physiological system with stresses. Suitable as reference for technical information.

Pelletier, K. Mind as Healer, Mind as Slayer: A Holistic Approach to Preventing Stress Disorders. Dell, 1977.
Marshalls much evidence (some controversial) on psychosomatic aspect of much illness. Major sections on healing effects of meditation, autogenics, visualization and biofeedback. Emphasizes redesigning a wellness lifestyle.

Selye, H. Stress Without Distress. Lippincott, 1974.
Legendary pioneer writes on his decades of physiological research on the General Adaptation Syndrome and his proposal for a world based on "enlightened self interest." Makes room for tireless "racehorses" like himself as well as "turtles." Alternates philocophy and physiology.

B. On Understanding and Managing Overload and Burnout

Bates, C. & Van Dam, C. The Path of Least Resistance: Isolation and the Paradox of Burnout Management in Personal Survival: Module Two (this volume). Advocates paradoxical re-framing, i.e. minimizing the stress of worrying about impending burnout by anticipating and accepting it as a temporary occupational hazard. Emphasizes cognitive interventions.

Bramhall, M.F. Burnout: The Subtle Thief of Program Effectiveness. Unpub. Mimeo (#211-9119 Manchester Rd., Silver Spring, Maryland, 20001). Incorporates five strategy programs including R.E.D. wellness triad (Albrecht above) plus cutting back on work load and non-nurturing relationships for first part of a four-week sequence of restoration (5pp.).

Cherniss, C. Professional Burnout in Human Service Organizations. New York, 1980. Cited in Bates & Van Dam.

Edelwich, J. Burnout: Stages of Disillusionment in the Helping Professions. Human Sciences, 1980. Four-stage model of decline from idealistic enthusiasm (based upon unrealistic expectations) through stagnation, frustration/anger to apathy. Author is social worker who uses many examples from his workshops and work with helpers. Good range of strategies including organizational.

Freudenberger, H. Burnout: How to Beat the High Cost of Success. Bantam, 1980. First-hand anecdotes and advice from a New York Clinical Psychologist with many years experience with burned-out professionals who tended to suffer from the effects of thwarted perfectionistic striving. Mostly geared to Type "A" strivers like he was when he experienced a total collapse working two full-time jobs. Seems to be the most widely known book of this type.

Greene, G. A Burnt-out Case. Bantam, N.Y., 1962.
Africa is the setting for this novel which connects the changes in a protagonist's spirit and faith to leprosy.

Howard, J., Cunningham, D., Rechnitzer, P. Rusting Out, Burning Out, Bowing Out: Stress and Survival on the Job. MacMillan, 1979.
One of the few resources to give prominence to the burnout opposite -- rusting out from too little challenge, dead-ending, etc. Not familiar with this reference.

Pines, A.M., & Aronson, E. Burnout: From Tedium To Personal Growth. Free Press, 1981. Based upon years of work including over 100 workshops and research with 4000 subjects and clients by leading burnout researcher (Pines) and her eminent social psychologist collaborator. This book makes a major distinction between exhaustion reactions caused by chronic or repeated emotional pressures from aspects of intense long-term involvement with people (burnout) and exhaustion from other pressures (tedium). They co-exist. An impressive and helpful look at personal, social, and organizational levels of intervention. More academic tone. The only one of this group not yet in paperback.

Pines, A.M., & Maslach, C. Characteristics of Staff Burnout in Mental Health Settings. Hospital & Community Psychiatry 29, 4, 1978.
A classic paper by the premier research team. First to document relatively acceptable strategies already in use among harried helping professionals (1973-1975) including a certain amount of: detachment ("detached concern"), intellectualization, home/office compartmentalization, withdrawal from clients, and emotional reliance on peers for relief. Includes many risk factors not found in other sources.

Veninga, R.L., & Spradley, J.P. The Work Stress Connection: How to Cope With Job Burnout. Little, Brown, 1981.
Cultural anthropologist and behavioural scientist team up to study the key factors in depleting and restoring "adaptation energy" (Selye) among 100 occupational groups they studied intensively. They divided the path to collapse as having five stages: energy-squandering "honeymoon";tired escape-seeking "fuel shortage"; uncontrollable "chronic symptoms" (exhaustion, illness, acute anger, depression, etc.); incapacitating "crisis" in physical and emotional functioning; and (rarely) "hitting the wall" of total career-threatening collapse.

C. Understanding and Managing Unrealistic Thinking and Expectations

Bates, C. & Van Dam. The Path of Least Resistance. Module Two (this volume). Introduces cognitive therapies and the destructive effects of false alarms produced by resistance to reality.

Burns, D.D. Feeling Good: The New Mood Therapy. Signet, 1980.
Self-help book for the depressed by psychiatrist who was trained by Beck, and helped him evolve or "found" his version of Cognitive Therapy. Tremendous overlap with Ellis' R.E.T. Among the best chapters for this topic are "Your Work is Not Your Worth" (13) and "Dare to Be Average: Ways to Overcome Perfectionism"(14).

Greenberg, D. How to Make Yourself Miserable. Random, 1966.
Hilarious antidote to taking self-defeating habits too seriously. Filled with loads of insightful lists and charts for guaranteed misery-making via "3 dimensional worry." Enables the reader to identify how easy it is to rationalize regretting or worrying about every aspect of life. If he who laughs lasts, then this book could do a lot for endurance.

Jewett, R.J., & Lawrence, J.S. The American Monomyth. Anchor, 1972.
Cultural anthropologists detail the all-pervasive role of this dependency-fostering myth upon which America was founded. The culture has always been conditioned to expect to be rescued from danger by a superheroic mysterious stranger like the Lone Ranger, Captain Kirk, etc. who will then "ride off" (having required nothing) until the next crisis in paradise. Any care-giver who is uncritically drawn into the Messiah Complex of the redeemer-figure is a prime candidate for burnout. A stinging but witty modern analysis. Hardcover.

Kopp, S. End To Innocence: Facing Life Without Illusions. Bantam, 1978.
A therapeutic classic suitable for anyone with more than a hint left of "pseudo-innocent" paranoid mistrust or pollyannish naïveté. He convincingly argues, mostly from the experience of his own life (as child, neurosurgery patient, and clinical psychologist), that we are no more realistic to expect rewards and protection for our decency than to expect to be singled out for misfortune. Knowing that life is not likely to be particularly "fair" to anyone can relieve much pressure from needless striving, figuring, etc.

Lazarus, A., & Fay, A. I Can If I Want To. Morrow, 1975.
A systematic cognitive therapy program for challenging twenty of the most common and destructive mistakes in thinking and the faulty assumptions behind them (e.g. don't make mistakes). As action-oriented as a muscle-building course. Lots of written work.

Machlowitz, M. Workaholics: Living With Them, Working With Them. Mentor, 1980.
Prize-winning investigative journalism from a management psychologist who studied 100 workaholics in depth. Accepts workaholism as an often satisfying albeit risky personality pattern which changes little over a lifetime even in retirement. Includes helpful suggestions on "Making it Work for You" rather than allowing it to be an affliction. Ends with Churchill's affirmation: "Those whose work and pleasures are one are fortune's favourite children."

McKay, M., Davis, M. & Farening, P. Thoughts and Feelings: The Art of Cognitive Stress Intervention. New Harbinger, 1981.
Reviewed above. (Module Two, Section "A") Includes extremely well condensed section on "Combatting Distorted Thinking." One dozen cognitive behavioural strategies.

Persig, R. Zen and the Art of Motorcycle Maintenance. Bantam, 1974.
Brilliant off-beat classic by one of most penetrating exponents of quality and getting things to work the way they were designed to. Narrative about a motorcycle trip and repairs is interspersed with mini-discourses related to fixing ourselves. Ch. 26 may unwittingly sum up the arguments against Type "A" impatience more powerfully than the technical literature does. In this chapter, Persig provides a crash course in Gumptionology -- the maintenance of "the psychic gasoline" that keeps things going. Among the energy-draining gumption traps which block us from fixing and taking care of ourselves better are: value traps (rigid priorities); ego traps (too much face to lose); anxiety traps (failure phobia); boredom traps (loss of "beginners mind"); and impatience traps (unrealistic expectations). When each of us made presentations on our notion of Quality Service in an ongoing "Quality Circle" at the beginning of the Manitoba project, Persig's book was instrumental in keeping our gumption and enthusiasm (i.e. spirits) high.

Watzlawick, P., Weakland, J., & Fisch, J. Change: Principles of Problem Formation an Problem Resolution. Norton, 1974.
A powerful source of information even if the overly technical parts are skimmed. Advocates use of paradox, re-framing, and systematic ways of seeing problems with new eyes. See Bates & Van Dam's reference.

D. Understanding and Managing Uncontrollable Human Suffering

Kopp, S., End to Innocence: Facing Life Without Illusions. Bantam, 1981.
Challenges disenchantment brilliantly by reminding us how suffering often occurs randomly even for the so-called "magic helper." Demonstrates the paradoxical way in which the most idealistic and dedicated care-givers often have the worst problem coping with pain and "bad luck" (their own and others').

Kushner, H.S. When Bad Things Happen to Good People. Shocken, 1981.
A Rabbi-counsellor's struggle with the premature aging and death (through progeria) of his beloved son. Reaches some of the same conclusions Kopp reached under the previous topic, i.e. none of us can expect to get what we deserve whether we are "nice" or not.

E. On Understanding and Managing Personal Planning

Adams, J.D. Understanding and Managing Stress. Univ. Assoc., 1980.
Module II. Self-Awareness and Personal Planning.

Anstin, M.G. Voyage: A chartbook for Career/Life Planning. Kendall/Hunt, 1980.

Bolles, R. Three Boxes of Life (And How to Get Out of Them): An Introduction to Life/Work Planning. Widely acclaimed as the best guide ever for those interested in life/career planning and job-changing. Brim-full of every conceivable type of question and resource -- all done with sparkling wit and captivating layout like its esteemed predecessor "What Colour is Your Parachute?" (1972). Of course, just knowing that there is a suitable parachute career to fall back on at the right time can alleviate much stress. This is the ultimate resource for getting your life "together." Instead of the traditional life compartments of education, then work, then leisure (retirement), Bolles advocates pursuing all three for life and provides almost 500 pp. of resources to facilitate the process.

Flach, F. Choices. Coping Creatively With Personal Change. Bantam, 1979. By psychiatrist who wrote "The Secret Strength of Depression."

Kirn, A.G. & Kirn, M.V. Life Work Planning/Life Work Planning Training Manual. McGraw Hill, 1978. Unfamiliar.

Lakein, A. How to Get Control of Your Time and Your Life. Signet, 1973. A very practical detailed plan by an internationally successful full-time specialist. His well-known strategies include frequently asking the question "What is the best use of my time right now?" He also recommends A, B, and C ("ignore") priority categories. Could make matters worse for some such as the clock-watching Type "A" Personality.

Miller, G.P. Life Choices. How to Make Critical Decisions -- About Your Education, Career, Marriage, Family, Lifestyle. Bantam, 1981. Counselling Psychologist's program -- used widely especially in business and education.

Neidhardt, J., Weinstein N.S., & Conry, R.F. Stress Management Series. Module Three. Personal Planning Skills. Western Center Health Group, 1982. Includes mental clearing, worry control, time management, goal-setting, problem-solving, and expectation analysis.

Sheehy, G. Passages. Predictable Crises of Adult Life. Bantam, 1977. Aside from normalizing your experience, this book can help to reduce the stress and energy-drain of crises because much of the adjustment can be done in advance when the crises are anticipated to some extent. The idea here is not to completely avoid the common crises (including burnout) but preferably to encounter them realistically and openly since they may facilitate breakthroughs into a more satisfactory lifestyle.

Porat, F. Creative Procrastination. Harper & Row, 1980. A holistic approach in pursuit of wellness more than speed. Maintains that time management is of NO value unless it frees time for the human side of life.

MODULE THREE
RE-NEGOTIATING: Towards boundaries, confidence, job reform

A. On Working at Unfinished Family Business

Halpern, H.H. Cutting Loose: An Adult Guide to Coming To Terms with Your Parents. Bantam, 1978.
A self-help book by a very experienced clinical psychologist. Gives thorough descriptions of various parental personality styles, along with ways to understand and step out of the old "songs" and "dances". Best of its kind.

Satir, V. Peoplemaking. Human Sciences, 1972.
Describes four major communicating and coping dysfunctions (distracting, computing, blaming, placating). The constructive versions of these styles correspond to the headings of our four stress reduction modules.

Weinhold, B. & Andresen, G. Threads: Unravelling the Mysteries of Adult Life. Marek, N.Y., 1979.
A well-organized workbook including several unique inventories for clarifying parental injunctions, illusions, myths, assumptions, role expectations, etc. The approach is a variant called Permission Therapy which includes exercises for learning to forgive your parents as well as yourself and others for being human and limited, etc.

B. On Working at Reducing Guilt, Manipulation and Over-Commitment

Alberti, R.E. (ed.) Assertiveness: Innovations, Applications, Issues. Impact, 1977.
This book is a collection of 35 articles on a wide range of applications including job hunting, work myths about assertiveness, and assertive skills on the job for nurses in dealing with work overload, setting limits, etc. Hardcover.

Alberti, R.E., & Emmons, M. Stand Up, Speak Out, Talk Back. Pocket Books, 1975. The concise updated version of "Your Perfect Right."

Fensterheim, H. Don't Say Yes When You Want to Say No. Dell, 1975.
The largest chapter in this behaviourally oriented approach is devoted to "Assertion on the Job."

Lange, A.J., Jakubowski, P. Responsible Assertive Behaviour: Cognitive/Behavioural Procedures for Trainers. Research Press, 1976.
Best integration of Cognitive and Behavioural approaches. Lots of good exercises, dialogue, application.

Smith, M. When I Say No I Feel Guilty: How to Cope Using the Skills of Systematic Assertive Therapy. Bantam, 1975.
Emphasis in this widely-used book is on how to non-defensively and persistently negotiate a way of meeting needs without succumbing to

manipulations designed to hook feelings of guilt, anxiety, and ignorance. Includes a section on responding better in supervision and authority situations.

C. On Changing the Working Conditions

Adams, J.D. Understanding and Managing Stress. Module Five. Managing Work-Related Stress. University Associates.

French, J.R.P. & Caplan, R.D. "Organizational Stress and Individual Strain". The Failure of Success. A Marrow (ed.) Amacom, 1979. Second-hand recommendation. Unfamiliar.

Miller, N.J. & McSweeney, A. Critical Issues for the Solo Mental Health Worker. Personal Survival Issues. Module Three (this volume). Includes a variety of ways in which organizational field practices could be revised to improve the quality of supervision, etc.

Persig, R. Zen and the Art of Motorcycle Maintenance. Bantam, 1975. An entertaining and stimulating series of discourses on quality and individual differences. A gold mine.

POSTSCRIPT

NOTE: Two absolutely outstanding modular stress reduction programs were cited above (Adams; Neidhardt et al.) which will never be stocked in book stores. Since they have already been field-tested on thousands of participants and cover much of the material cited above, they can be recommended without reservation. If your region doesn't have much chance of getting enough of the other books locally and you don't mind pre-packaged workbook material, the packaged material might be much simpler in the long run.

Ordering Information

1. Adams, J.D. Understanding & Managing Stress.
    1. "Workbook" - includes modules on: Understanding Stress, Creating and Using Support Networks, Managing Work Related Stress, Holistic Living (Nutrition, Exercise, Letting-Go Techniques (i.e. Relaxation Response), Self-awareness and Personal Planning.
    2. "A Book of Readings"
    3. "Facilitator's Guide"

Order From: University Associates, Inc.
8517 Production Way
P.O. Box 26240
San Diego, CA 92126

2. Neidhardt, J., Weinstein, M., & Conry, R.F. Stress Management Series.
Includes seven modules: Introduction; General Health and Well-being; Personal Planning Skills; Communication Skills; Quieting; Autogenic Methods; Progressive Relaxation Training. ($35 for set)

Order From: Western Center Health Group
820 - 1090 W. Georgia St.
Vancouver, B.C. Canada V6E 3V7

Critiques and up-dating for this catalogue (and the entire section) will be gratefully received by the editor:

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Langley, B.C. V3A 4P9

SECTION TWO: "PROFESSIONAL SURVIVAL"

Section Editor: Ron Brown
Executive Director
Canadian Mental Health Association
(British Columbia Division)

PROFESSIONAL SURVIVAL ISSUES FOR THE RURAL MENTAL HEALTH WORKER*

by Francis J. Turner, D.S.W.,
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INTRODUCTION

Recurring conferences on rural mental health speak well for this general area of practice here in Canada, for they bring into focus for the professions an important component of Canadian life: the reality of practising in geographically dispersed areas. As a resident of that most eastern of western provinces, Ontario, I am most pleased to have been invited to contribute to the 6th Western Interprovincial Conference on Rural Mental Health, and to the Handbook arising from it. At the outset I wish to make it clear that I do not speak as a current expert in rural mental health practice. Some years ago, I practiced for several years in a psychiatric hospital setting which involved a large network of rurally-based approved homes. This and other experiences have developed in me a particular interest in the challenges of rural practice, where one is far from the large urban centres both in miles and in perception. But I cannot present myself as a contemporary specialist.

Most of my comments are from the perspective of social workers, the group I know best. I do not adopt this approach out of a spirit of insularity or professional isolation. On the contrary, I am convinced that the lines between professions become even more diffuse in Rural Mental Health than in other settings; and this I consider to be a good thing. No, I am commenting from a social work perspective because I can speak with some authority to my colleagues. I have always objected to people who are ready to tell those in other professions how to run their lives; nevertheless, I do hope and believe that my comments will have some relevance for all professionals in this area.

"City Slicker" vs. Rural Cousin

Let me begin with an attitudinal theme, looking at our own self-perceptions as workers active in the field of rural practice. In recent years I have become most interested in our similarities as practitioners -- similarities that persist even though we practise far apart from each other. During my professional practice years I have had the opportunity to work with social workers in several rural areas both in Canada and outside of Canada: the Canadian Arctic, Barbados, Newfoundland, rural Ontario, Northern Ontario, Northern Scotland and Israel. An attitude that is all too common among these colleagues implies that, by definition, practice in rural areas is somehow second-class or second-rate; that the real cutting edge of the profession is to be found in the large urban centres. It is very much the city slicker/rural cousin dichotomy played out again and again. What is particularly upsetting about this attitude is that it is usually based on a totally false premise. Repeatedly I have been impressed with the knowledge, skill, competence, ingenuity and resourcefulness of practitioners in rural settings. Not only do they have nothing for which to apologize but in fact they are often ahead of their discipline. Certainly they often lack resources; but this is quite different from lacking competence.

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* Based on a keynote address delivered to the Sixth Western Interprovincial Conference on Rural Mental Health, Kelowna, B.C., September 15, 1981

My most urgent appeal to you therefore is to try and break out of that mind-set, if indeed you are in it. An important question to ask is "who defined rural professionalism?" There is a risk that we may unnecessarily perpetuate the attitude that we are so different that we need to meet separately. In fact we might be in a much stronger position if we refused to be identified as a special sub-group of our profession. I do not want to belabour this point, except to point out that there may be a "self-fulfilling prophecy" risk in maintaining too long and too strongly a separate identity.

To counteract this, it is vital not to get too cut off from our respective professional groups. There is an important place for the specialist group in any profession. This remains true as long as we are perceived - and, most importantly, perceive ourselves - as specialists and not variants or, even worse, deviants within the profession. Thus it is important to remind ourselves and each other that we have much to contribute to the developing knowledge base of our total profession. We have much to teach our colleagues who practise in non-rural settings.

Leadership, Autonomy, and Self-image

One of the major contributions Canada can make on the international scene is to demonstrate how a country like ours can develop a service delivery system that copes with the extreme challenges of weather, vast distances, and geographical obstacles. We have the potential to become world leaders in this field: leaders rather than followers in our own disciplines.

I speak with some conviction about this from the perspective of my current position at Laurentian University. Our mandate is to bring university-level education to the north-eastern part of Ontario. If you look at a map you will realize the size of this parish: it is not only huge but also highly isolated, with some of the worst weather this country can provide. Our professional schools, such as nursing, social work, and education, are very interested in the challenge this presents. Ever so slowly we are learning that it is a mistake to measure our quality according to how closely our curricula, programs, and teaching methods resemble those of more urban-oriented universities.

Certainly one of the things we have to learn quickly as rural practitioners is to define our identities from within: from our convictions, our values, our commitment, and our own sense of competence. I am speaking here of the need for a healthy and strong self-image that says "I am good"; or, to misquote the Speedy Muffler Company, "I am a Somebody." I mention this because so much of the self-identity of many professionals comes from group reinforcement, from people who are performing similar tasks and roles. It is easy to be sure of who you are in a large agency when there are 20 or 30 colleagues of the same profession doing similar tasks. It is frequently much more difficult to maintain that sense of professional identity when you are alone, performing many activities that have little to do with what traditionally might be thought of as your own role. In our society the traditional lines between professions are going to become blurred with the dramatic explosion of knowledge. If so, our professional survival will be related to a strong sense of self-worth and competence rather than to a specific role that we play in society. We will survive professionally if whatever we do is done extremely well, in a responsible, accountable manner.

Hence a basic requirement of professional survival in rural social work is a strong sense of autonomy. We cannot hide behind a particular role set, but must develop our own -- one that best serves to fulfill our particular responsibilities. Frequently we will have to fight very strongly to find acceptance for the role; but we must define that role ourselves, and not leave it to others. We must work to become comfortable with a diffuse and varied role, and accept as a part of reality that this role will be questioned and challenged. As a social worker I am less and less concerned that many other professionals in other disciplines can do many of the things I can do. My only concern is that what I do be at the highest level of available knowledge and competence. We should all welcome responsible competition.

Certainly we are not in rural practice very long before we learn that we will be doing many things that they did not teach us in school. A social worker in Newfoundland told me that one of his first tasks as a public assistance worker in a highly isolated outpost was to row across a bay each night, alone in a dory, to an island where he would bury the bodies of people who had died that day from a very serious flu epidemic in the community.

On my first visit to the Arctic to look into the living conditions of the aged Inuit, I found myself helping the Mounted Police veterinarian inoculate dogs. My job was to hold down the back legs of the dog while a young constable held the front as the shot was given; at which point we would let go of the husky and run like hell. Each time we did this I was terrified and tried to look brave; however I soon found that the policeman was shaking just as much as I was. In return for this help I was able to get a ride in the plane to the various camps to interview the old people.

Donald Krill, a social worker in Colorado, has published a very interesting book entitled Existential Social Work, in which he develops a theme that the existential social worker needs to learn to stand alone: to be on the edge of the crowd looking on; to find his authenticity in his own belief in himself, not in the acclaim of others. I think most social workers in Rural Mental Health practice need to have some existential commitment for professional survival.

I realize that this discussion of autonomy overlaps with the topic of personal survival, but I view it as also essential for professional survival. In summary, to survive professionally in these settings requires confidence in who we are professionally. This comes from our own evaluation of our responsibilities, not from a role-set that is defined entirely by others or by the setting.

Technology and Excellence

I do not believe our task is only to survive professionally. Rather our commitment should be that we excel professionally, that we become the acknowledged leaders in competence and service delivery. Fortunately we are living in a era in which, for the first time in human history, we have a wide range of resources available that can enhance our abilities to communicate with clients, with communities, and with each other, regardless of our geographic location. It is in this area of technology that I believe the rural mental health practitioner can make a major contribution to his or her professional identity. For an interesting discussion of the possibilities I refer you to a Canadian book entitled Gutenberg 2 which talks about the reality of all information being now available everywhere in the world, all of the time.

Canada is a world leader in some fields of communications technology, such as satellite T.V. and the whole new world of fibre optics. This latter development is going to permit interactive television: we will be able to talk back to our T.V.'s and converse with others through the medium of T.V. There is a possibility that most home T.V. sets in the near future will have fifty to sixty channels available permitting various kinds of interaction. This development has distinct possibilities for us in rural mental health. There have already been some exciting developments in the general area of "Tele-medicine"; rapid transfer of medical information now permits diagnosis and consultation from a great distance.

Think of the possibilities of this resource for family therapy, for the interviewing of remote clients, for meetings with colleagues who are widely separated, and for crisis intervention from a distance. I often think of the vast amounts of time and money we spend in rural practice on visiting clients. Some of you have no doubt experienced situations in which it took a whole day or even more to make one home visit. Think of how much more effective we could be if we could talk to Mrs. Murphy and her family by two-way television for an hour or so each week.

Of course this kind of idea is not new. Again I remember my first trip to the Arctic where part of my responsibility in the community was to be in charge of the short wave radio in the evening. On one of my very first evenings an Inuit family came into the house and sat around in a half-circle in front of the radio to talk to a member of the family who was in another community receiving medical care.

I am not suggesting that this technology will ever fully replace direct contact with clients, but I do suggest that it can and must play a critical role in the provision of mental health services in the rural regions of this country. Now I am aware that I may be preaching to the converted. A number of interesting experiments are already going on in various regions of the country, studying uses of these new resources in all aspects of our practice; for example I believe there are some video hook-ups in the Eastern Arctic that permit meetings between community leaders and various Inuit settlements.

The point I want to stress is that in this task of professional survival to date we seem to be making very little organized use of these resources. These technological developments are probably the most important new breakthrough in mental health services that we have had in two decades. We must seize this opportunity and make use of it; and we must share our experiences with each other. Yet I note that neither at this conference nor at the recent National Conference on Rural Mental Health (Sudbury, September 1-3, 1981) have we addressed this issue as a critical topic. A most exciting theme for another conference would be the use of technology in rural mental health services.

"Think Scientifically"

In a recent article in the American Social Work Journal, Joel Fischer from Hawaii talks about a quiet revolution that is taking place in the profession: we are moving from a willingness to base our practice on haphazardly-gathered practice wisdom to a firm commitment to developing a much stronger empirical base for practice.

I think this is a valid observation. In recent years we have moved from a position that saw the roles of practitioner and scientist as a dichotomy to one in which they are rapidly becoming a unity. I am firmly convinced that this is an essential shift that all of us in rural practice must make for our professional development. The term "Scientific Clinician" or "Scientific Practitioner" or "Practising Scientist" helps describe this new role. What is meant by this term is not that we all become researchers and theory builders in the traditional sense, but that we build into our value set a strong commitment to accountability, a relentless search to understand what we do, a restlessness to discover why things happen in a particular way, and that disciplined skill of observation. The new role of the scientific clinician can do much to enhance our sense of autonomy because it puts us directly in touch with that critical question "How am I doing?" - a question that so often haunts us in a vague, diffuse way, especially when much of our practice takes place far from large centres and the reinforcement of our colleagues.

"Think Small"

But in moving to this attitudinal position of the disciplined observer and recorder I encourage a second value shift that leads us to think small. I am becoming more and more convinced that one of the reasons we have not made great progress in this area of practice is because we have looked for major changes or dramatic breakthroughs. Again I refer to social work; I am certain that progress in this field will take place by dint of many hundreds of small, carefully-conducted evaluative efforts, not through massive evaluative projects that ask such questions as "are trained people effective?", "does family therapy work?", or "is this alcohol programme useful?" Too often we set impossible goals for evaluative and demonstration efforts, and hence are doomed to failure. We will progress when we settle for small but respectable and demonstrable changes in predicted directions. We will advance in our professional effectiveness and thus in our societal worth to the extent that we strengthen our commitment to a much more disciplined, evaluative, goal-oriented approach to our practice.

Accountability and Peer Criticism

However, if we move into this role of the scientific practitioner, other sub-roles or components of the role set follow. As we add to our professional identity of "socially-concerned practitioner" the role of "disciplined observer" we must also then become committed to the concept of peer criticism. As we seek to make our practice more accountable, we must become much more committed to public scrutiny by our colleagues. As we do this we will be able to establish better base lines; i.e. we can identify realistic expectations of various components of our practice. This is a critical concept. One of our greatest difficulties in the mental health field is in knowing what is good enough, what we can expect from one-to-one intervention, from groups, from educationally-oriented projects, from outreach projects.

Unless we can establish base lines, we will have nothing to use as a basis of comparison. Because of this lack of base lines I am convinced that we are frequently much harder on ourselves than need be, and thus fail to recognise aspects of improved service or improved intervention because we shoot too high. For example, a parent effectiveness training program might be viewed as a failure because on a follow-up study only 20% of the parents have maintained a certain level of altered behaviour. However, it may well be that this is a major step forward if the base line indicates that a 15% sustained improvement is what is expected. I do not mean that we should not try to change baselines; what I do mean is that we will not know if improvements are being made if we have no standard against which to measure.

Sharing Practice Experience

Thus we need to share our practice outcomes with groups of our colleagues. This can be as simple as small groups of colleagues with similar interests coming together; or as formal as papers presented at conferences, or articles in journals. All of these are important, no one more important than the others. What is needed is much more sharing of our tested practice experience so that we can take advantage of our demonstrated successes or failures in practice. We can learn just as much from our failures as from our successes; what is important is to be able to identify and agree on what is a failure and what is a success. This is not always easy to do.

In a similar way we need to become much more visible in the literature of our various professions. No doubt there is a need for journals which pay particular attention to professional developments in rural practice, and here again we in Canada could make a major contribution by establishing an international rural mental health journal. But we must not restrict ourselves to specialized outlets; we must play a very visible and aggressive role publishing in those professional journals that cut across the whole spectrum of our various disciplines.

Before I leave this point, let me remind you that just as there is an important place for technology in direct practice, so is there an important place for technology in our search for new knowledge. As scientists, our commitment is to use whatever is ethically available to us. The telephone, the cassette recorder, the video tape, the interactive television set and the microcomputer must all become part of our regular arsenal of skills and equipment. Here again we should think small. Too often we think of these technical resources as large, complex and expensive. In our day none of this need be. One of the few areas in our wild, oil-driven economy where prices are coming down is the world of electronics. All of us can afford to own and use these resources once thought to be available only to the large research centre, company, government department or university. Right now it is completely possible that practitioners in Newfoundland, in Northern Ontario, in the Territories and here in Central B.C. could share outcomes in similar cases on a weekly basis through phone-connected computers.

Universities

If we do internalize the never-ending search for knowledge and skill and evaluative capacities then it follows that we must be students the rest of our lives. All areas of knowledge are expanding; just a glance at the book review section of any of our professional journals quickly discourages us as we sense how much is taking place in all of our fields. But how do we cope with this knowledge explosion - especially those of us in rural practice, for whom universities are often completely inaccessible?

Here there is a very dramatic twofold responsibility. We practitioners must be much more organized and articulate in relating our needs to the educational community. On the other hand, we at the Universities must be more responsive to the needs of the profession. We must avoid the great mistake of getting into a useless intersystemic battle where each side blames the other. There are dramatic changes in attitude taking place in Universities, both about our responsibilities to outreach education and, even more importantly, about the technical and pedagogical methods required to deliver in this area. We are just beginning to learn how to make most effective use of the new technology in providing professional education to distant, widely-dispersed practitioners. I suggest that practitioners need to play a major role here. It is now a matter of know-how and resources rather than commitment.

Using Our Own Educational Resources

But all new learning need not come from the Universities. As rural practitioners there is much we can do ourselves. Certainly we must read, and this is something of which we just do not do enough. We must make use of short courses given through a correspondence mode. We must take advantage of the wide range of educational cassette tapes now available. If you have not as yet tried these I urge you to do so. The last car we bought has a cassette recorder in it and I find it extremely pleasant to take along a few cassette tapes and play them while driving. There is now available a wide range of tapes on many aspects of mental health. A very important project for this group of colleagues would be to develop and circulate relevant cassette tapes to each other. They are inexpensive to produce, easily duplicated, easily transported and very durable. This is one good way for colleagues to share professional findings and development across long distances.

Conclusion

Implied in my remarks here is a dual, perhaps seemingly contradictory message.

As rural mental health workers we need to be comfortable as autonomous practitioners, but closely united to our fellow practitioners. We need to be highly identified with our own professional roles; but we must also be comfortable crossing professional lines and intermingling with many groups of people - groups in which our professional identity becomes merged, buried or even invisible. We need to stay strongly linked with our professions on a large scale but equally identified with the special needs, demands and developments of our particular components of practice. We need to retain our commitment to the larger policy goals of the societal mandate we carry; but we must also be aware of our responsibility to represent the needs of our clients and communities, and seek to change social policy. We need to be aware of the development of knowledge in other areas of our own and allied professions, but also aware of our responsibility to influence these developments by bringing to the fore our personal insights and tested observations. A vast array of contradictory roles! Survival not only as professionals but as human beings will depend on our ability to function comfortably in this highly complex and frequently contradictory role set.

We are confronted with the fiscal reality of lack of resources. I need not dwell on this except to say it is a culture-wide phenomenon. I am not an advocate of comfortably accepting the status quo. There is, however, a risk that we may blame all our problems on a lack of resources and thus absolve ourselves of all responsibility. I said in a paper in Ottawa a year ago that in times of restraint we can become bitter, bored, belligerent -- or better. I am convinced that the last option -- becoming better -- is the only course to follow. There is much we can do to improve the quality, effectiveness and efficiency of our mental health services in a time of great fiscal restraint. To do so requires that we internalize the attitudes of the humble, aggressive, curious seeker of wisdom that are the mark of the responsible practitioner of the late 20th century.

I do not think the question to be addressed is "what are the survival issues for the rural mental health practitioner?" Rather, I believe we have two choices: either disappear or improve. I am an optimist. I do not think there has been a time in our profession when we have had as great an opportunity to contribute to the enhanced psychosocial functioning of members of society than the present. Each of us will approach the task differently; and this is good. All us, aware of our limitations, will learn to value the individuality of others and the benefits of sharing knowledge; and this is better. Together we will make our knowledge available to society, as is our commitment; and this is best.

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CONTINUING EDUCATION — A RURAL FIELD PERSPECTIVE: OPTIONS & BUREAUCRATIC RESPONSIVENESS

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ABSTRACT

Programs geared toward personal growth and development and stress management are not generally sponsored by government. Industry, however, often pays for such things, and in this respect gives the impression of being more concerned about the health of its staff.

In bureaucracy there exists a paradox about continuing education in that turnover and burnout (often the products of a lack of on-going training) are cited to justify short-range cost-effective management and neglect of continuing education. Senior management must take the initiative in the development of "growth profiles" for staff, and staff must recognize their personal responsibility for their own professional growth. The Manitoba In-Service Training Program and the B.C. Electives System are described.

Introduction

While this topic is appropriately included in the Professional Survival section, there are also important links between Continuing Education and both Personal and Program survival. Though Continuing Education is most often intended to increase professional knowledge and skills, lack of appropriate learning opportunities can contribute to stress and burnout of overwhelmed staff. Successful mental health programs require competent and committed staff. Though such characteristics may be present at the time of hiring, they can dwindle away without careful nurturing by program supervisors and administrators.

Manitoba In-Service Training

The Manitoba Community Mental Health In-Service Training Program was approved in 1977 and continues to be offered. The topics, listed in Chart 1, are presented in separate modules of one to five days' duration. Benefits anticipated by the program planners are listed in Chart 2.

Modules are offered primarily to Community Mental Health Staff, both supervisors and field staff, with extra spaces available periodically to staff of other provincial human services programs. Instructors have included professionals within the Manitoba mental health system as well as teachers and practitioners from other settings both within and outside Manitoba.

Participation is voluntary and is consistently high. Pre-reading materials are widely read. Because supervisors and staff are jointly exposed to new and updated knowledge, new concepts and opportunities to practise skills, there is empathetic support and knowledgeable advice available to those feeling the stress of trying the unfamiliar.

Registrants in most sessions come from most or all Regions of the Province. As colleagues interact, such anticipated benefits as development of program identity and sharing of ideas (e.g. methods of coping with isolation and other stresses) materialize.

CHART 1: COMMUNITY MENTAL HEALTH INSERVICE TRAINING PROGRAM - MANITOBA

List of Modules

- The Mental Health System in Manitoba
- Mental Health and the Law
- Community Entry and Community Dynamics
- Record Keeping
- Overview of Common Clinical Syndromes
- The Initial Interview
- Method Setting and Treatment Planning
- Psychopharmacology
- Interviewing, Counselling, and Communication
- Long-term Aftercare in the Community
- Behaviour Management Techniques
- Psychogeriatrics
- Crisis Intervention
- Community Mental Health Consultation
- Mental Health Education
- Family Systems-Oriented Approach to Mental Health Practice
- Clinical Supervision
- Depression

Proposed Additions:

- Confusing Physical and Psychiatric Symptoms and Conditions
- Treatment Approaches in the Field of Alcoholism
- Life Skills

CHART 2: COMMUNITY MENTAL HEALTH INSERVICE TRAINING PROGRAM - MANITOBA

ANTICIPATED PROGRAM BENEFITS

1. To offer consistent training for all community Mental Health Staff.

2. To provide knowledge and develop skills basic to service delivery.

3. To offer additional knowledge and skill development:

   - consistent with new program development.

   - for further growth and development of staff.

ANTICIPATED STAFF BENEFITS

1. To pursue one's goals of continued professional growth and development of knowledge and skills.

2. To offer opportunities for style and value shifts through the positive stress of being challenged.

3. To provide a learning break from day-to-day responsibilities and pressures.

4. To provide opportunities for geographically scattered staff to meet and

   - develop program identity.

   - learn how one's own skills and approaches compare with others.

   - share ideas, concerns, and frustrations.

   - share methods of coping with stresses of the job.

Continuing Education in British Columbia

In British Columbia, the Electives System offered by the Continuing Education Committee of Mental Health Services offers over 180 practice relevant workshops to more than 4000 participants throughout British Columbia at an average cost of less than $64 per workshop.

The key to the tremendous success of the Electives program is the effective use of mental health staff as faculty. Each year a canvas of professionals working within the four constituent parts of the mental health system is undertaken to enlist faculty. The recruitment of faculty and the development of workshop content are simultaneously undertaken, and the resulting workshop offerings, which are scheduled for centres throughout the Province, are listed in an "Electives Catalogue" that is distributed to each service delivery unit throughout the Province. A total of 37 faculty offering 41 workshops were listed in the 1980 Electives Catalogue. Seventy-five percent of these faculty were drawn from largely urban centres.

It is widely recognized that one of the serious problems facing government services today is the loss of the most experienced practitioners in rural communities as a result of turnover due to isolation and lack of professional stimulation. It is difficult to attract seasoned mental health professionals to rural communities, and it is also difficult to retain them for lengthy periods of time. There is little opportunity within most larger bureaucratic systems to successfully combat the effects of staff burnout, isolation, and lack of recognition, all of which combine to render rural communities particularly vulnerable to loss of their professional personnel.

The Electives System has addressed this issue squarely, and preliminary findings indicate that mental health turnover rates are now a less critical issue. In addition, seasoned mental health practitioners can be attracted to rural communities given the educational support systems that are now in place. Moreover, 25% of the 1979-80 "in house" faculty were drawn from specifically rural communities. Such participants are gaining significant recognition in other more isolated communities from this particularly relevant rural orientation.

Conclusion

A final concern relating to continuing education is that continuing education programs may cause stress and/or distress as participants struggle to develop a better means of coping on the job. Even when a learner approaches a new concept enthusiastically, there will be stress before the learner has become proficient with a new skill. When a new concept is perceived as threatening, perhaps because it's a challenge to a learner's own beliefs, or because it's seen as a challenge within an organization under stress, the response by the learner will be one of distress, at least initially.

In summary, the point should be underscored that well-planned Continuing Education programs are a necessity to support rural mental health staff in their fight against burnout and career isolation. Events such as the Western Interprovincial Conference on Rural Mental Health should be recognized as an excellent forum for professional training and information exchange.

MAINTAINING CONTACT WITH YOUR OWN PROFESSION:

DOES IT HELP?

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ABSTRACT

This paper reports on a workshop conducted by the author at the Kelowna Conference in September 1981. Before addressing the question posed in the title, the workshop considered actual roles, activities and skills of different workers. This was done by delineating profession-specific activities as well as activities common to all disciplines; and by looking at actual participation by different professional groups in the care of schizophrenic patients in four provinces, on which study data were made available. Group discussion led to various comments and recommendations, generally affirming the value of several distinct professional mental health disciplines.

Workshop

Before addressing the question posed, it is necessary to look closely at "your profession." What does it mean? It can mean your formal training, your actual role(s) in mental health services, or your "bargaining unit" for issues related to salary and working conditions. The workshop reported here concentrated on role issues.

There are profession-specific activities as well as activities shared by all professionals. Some of these were delineated briefly. It would appear, for example, that social workers have fewer discipline-specific tasks than other disciplinary groups. How much do we know about actual roles and activities in practice?

Data from a study of schizophrenic patient care in four provinces were presented. The distribution of professional activities and roles is surprising in some respects. Physicians still play the major role at all stages of patient care, and nurses predominate among non-physicians. Discipline-specific division of activities does not follow expected patterns for psychologists and social workers; however, it must be recalled that the patients studied represent a special group, in which medication is a central aspect of treatment.

Discussion/Recommendations

1. Some participants felt that person-to-person positive reinforcement and feedback, especially in profession-specific matters, are more meaningful when they come from within the profession. A minority maintained that they could obtain this kind of support from any other professional.
2. For training, salary issues and related aspects of professional identity, workers should maintain contact with their own professional groups and group standards.
3. Contact with the profession is a valuable source of continuing education, though other avenues should not be neglected.
4. Although the data presented suggest that a nurse is often the professional who can perform most tasks and be a "generalist," any trend towards staffing on the basis of a single generic professional ("do-it-all" mental health worker) model should be resisted.

The group laid emphasis on the high value of having input from the perspectives and skills of different disciplines. The diversity and complexity of client problems must be balanced by the richness and diversity that several professional disciplines can bring. Some people now regard themselves primarily as "mental health workers" rather than as members of a traditional professional group, but these are clearly in a minority.

In spite of considerable blurring of roles in current practice, it is apparent that each particular discipline brings definite strength, skills, perspectives and professional competence to community mental health care. All are necessary to respond to the challenge of the acute and stressful problems presented by the disturbed and distressed patient/client. This is particularly true for practitioners in rural areas who lack the support of the large body of fellow-professionals they would find in a city.

SOCIAL NETWORKING: A NATURAL HELPING SYSTEM FOR SOCIALLY AND GEOGRAPHICALLY ISOLATED PEOPLE.

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ABSTRACT

There is a great deal of evidence that informal helping systems are accepted more readily in rural environments than are the formal, government or privately sponsored agencies run by professionals.

The social network that exists in Port Hardy and the Comox Valley in British Columbia is described in the framework of "social network" as described in the literature.

Emphasis is placed on the professional mental health worker's role in developing a network of informal supporting relationships in underserviced rural areas.

Workshop

Mental health workers are overwhelmed by the needs and requests for services in rural areas. Providing direct service to a location one travels to once a month is hardly adequate. To feel so ineffectual lies heavy on the worker; providing services from a solo satellite office or a solo travelling clinic disconnects workers from their own helping "home base." Clients are dissatisfied with "waiting for the help to come" from the monthly mental health professional - a pattern of response that is frequently reminiscent of the rural clients' husband and wife dynamics at home, which may have triggered the need for mental health services initially. If we, as helping professionals, value and promote connectedness and support between people who care about each other on a personal level, then we need to develop helping systems that manifest these values on a community level. Once the worker leaves the rural area, clients have only the community to fall back on and sometimes, if fortunate, their own families. Even the social worker in a rural mental health clinic may be viewed with skepticism by the native population (Hanton, 1980). There is a great deal of evidence that informal helping systems are accepted more readily in rural environments than are the formal, government or privately sponsored agencies run by professionals. (Burke and Weir, 1981; Caplan, 1973; Coward, 1978.)

With this knowledge and belief that an informal delivery system of mental health services would more effectively meet client and worker needs, a social network of emotional support services for women began in 1976, in the Northern Vancouver Island community of Port Hardy, British Columbia.

Social networking is a particular type of informal helping system. In assessing the mental health needs of the Northern Vancouver Island region, the personal and interpersonal isolation and alienation experienced by women was found to be a predominant phenomenon. While assessing the resources available in that region through which this phenomenon could be addressed, a natural helping network of four former public health nurses and teachers was revealed. It had been operating for 10 years. As Sarason says, "Networks exist; they are not created." (Sarason, 1977)

The word network connotes a linkage of one to another, usually more than two, with communication as an implicit foundation for the network's development. The term social network is defined here as the interconnectedness of one with another for the purpose of enhancing the human potential of each individual through mutual exchange of skills and resources. The rationale for promoting social networking as a helping system for Northern Island women became quite clear. The four women of the core group were accepted by the region; they were waiting for encouragement to develop their helping potential; and they were willing to work hand-in-hand with the mental health professional who traveled there once every four to six weeks.

This core group soon drew into its midst several other women and two men who became participants in a course in peer counselling and group facilitating. Characterizing this social network was the cooperative involvement of both professionals and volunteers. This in turn led to the volunteer facilitators and clients working together in a "mesh network" for mutual support. The mesh network is a problem-oriented approach, with the client joining healing forces with the facilitators, as in Figure 1.

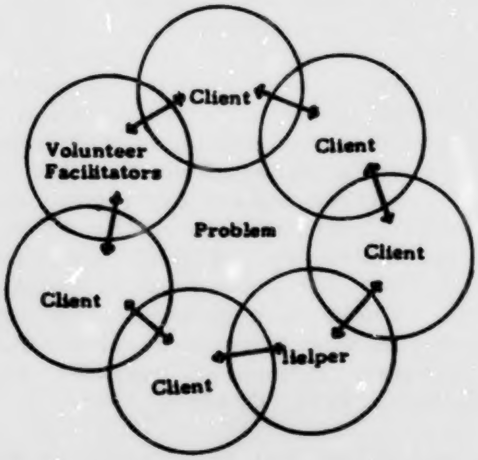

Figure 1: Mesh network

A contrast to this is the traditional model of helping, the ego-centered network in which the client is the focus of all the healing powers (Sarason, 1977), as in Figure 2.

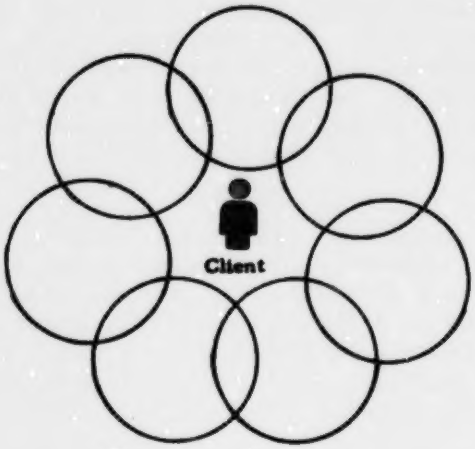

Figure 2: Ego-centred network

In the mesh network, reciprocal helping is inherent in the structure. This offers the facilitator (professional or volunteer) the connection and support necessary to recharge and to encourage new linkages.

Most North Island women believe they are alone with their "problem" (i.e., depression, anxiety, agoraphobia, psychosomatic illnesses, apathy). An ego-centered network can reinforce this "aloneness"; by contrast, the social network revealed in this particular rural environment gave the women access to each other, upgraded and/or utilized their skills, and recognized that each had contributions to make to each other and to the whole. These processes within the emotional support groups that comprise the social network became the "treatment," with the members as their own "helpers."

Those in the original training group soon went back to their small community or special project and initiated emotional support groups in their area. Among those groups were:

1. Three emotional support groups for women, sponsored by the community college and comprising women who learned of the group themselves and women who were referred by clinicians.
2. One support group for spouses of alcoholics or drug abusers.
3. One church group addressing teenage concerns in the community.
4. One pre-school parents' support group.

The connections among participants in the support group are analogous to those connections among systems on the macrocosmic level of social networking.

With this Northern Vancouver Island network as a model, another project began in 1977 in the Comox Valley, located in Central Vancouver Island. An "Expression for Women" course, an emotional support group for women experiencing social isolation, was offered six times between 1977 and mid-1979. Twelve facilitators, all previous course participants, were trained in the process. Peer counselling, co-counselling and group dynamics materials formed the basis of this training, with bi-weekly group supervision from the facilitators.

Together with a facilitator, the mental health professional began to consult with community support groups already in existence who wanted more information or training in this networking process. Among those requesting consultation were leaders of a Mothers and Tots group, a Parents in Crisis group, a pre-natal course, a single-parents group, a bereavement group, and a committee of teachers and parents concerned with delinquency problems. Thus, as the direct service network grew, so did the training network.

In the Fall of 1978, a proposal called "Perspectives for Women" was drawn up - a project designed to develop and deliver skills and information workshops on issues pertaining to women. In Spring, 1979, Vancouver Island was chosen as one of the ten target regions to pilot what was now called the Women's Services Training Programme. The objectives of this programme were:

a) to strengthen existing women's services

b) to network women's resources across Canada

c) to demonstrate the legitimate need for women's services.

This programme, out of necessity, took on an outreach and public education focus, frequently providing workshops co-sponsored by the Indian Friendship Centre, the Ministry of Human Resources, the John Howard Society, or Mental Health Services.

Throughout this process of presenting workshops, many women presented themselves as being in crisis situations - perhaps involving violence from spouses, child abuse, suicidal tendencies, and/or depression. While the population of women in crisis is most visible, there is a larger and less visible population under stress and in social or geographical isolation who are also at risk. Both populations need information about constructive alternatives, ongoing emotional support and some sort of programme which addresses itself to the integral needs of women in isolation.

The preliminary network promoted by the Women's Services Training Programme and the mental health professional, which provided both direct services (in the form of self-help groups) and training programmes, became the foundation for a larger project called The Women's Self-Help and Advocacy Network. This project was given funding by the federal and provincial governments for a three-year period to create self-help alternatives to meet the needs of women in rural communities. In providing skills and resources to help women to help themselves and others, the project encourages the development of community options, preventative programming, and strategies for dealing with crisis needs. The proposal for the Women's Self-Help and Advisory Network details the organization, goals, staff, funds, programs evaluation and follow-up of this project (Women's Self-Help and Advocacy Network, 1979). It is another way that the initial few linkages grew in number, strength, and scope through sharing resources, energy and vision, thereby creating a mesh network affecting the lives of many.

Social services, mental health services and other related agencies are either over-extended or non-existent in isolated communities. Professionals, however, can be instrumental in developing networks of informal, natural helping systems; and they themselves benefit from this process. One project, the Women's Self-Help and Advocacy Network, serves as a prototype for the development of social networks for socially and geographically isolated women.

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LOYALTY ISSUES: WHOSE CHANGE AGENTS ARE WE?

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ABSTRACT

The fundamental loyalty dilemma faced by many mental health workers can be summarized as follows: If the community mental health centre is involved with socially important problems at the community level and, if social validation techniques provide a means of evaluating the social acceptability of social service programs, and, if this process indicates that the general population does not agree with the directions of the mental health planners, then, what is the necessary and appropriate role of the local community mental health worker?

A literature review and specific references to the B.C. situation are used to provide some insight into this conflict faced by many rural mental health workers.

Introduction

As rural community mental health workers, we often function as spokespersons for our local communities. Equally often, we speak for our funding organizations. My question is whether this Janus-like role and the loyalty conflicts which may result are clearly understood by all concerned. Most of us have had experiences where the needs and expectations of our local communities and most of our parent organizations have not been in harmony. When this occurs, rural mental health workers are placed in a classic "pushme-pullyu" dilemma when determining whether our professional ethics, responsibilities, and loyalties lie within the host community or the parent organization.

When this type of dilemma occurs, it can result in one or the other of our constituents feeling misrepresented. This may have all sorts of negative consequences; yet the rural community mental health worker is left without any pragmatic professional guidelines for necessary and appropriate responses to these situations. Unless some strategies are developed and operationalized, we will continually find ourselves in situations wherein our proper roles as community change agents are diffused by confusions, misunderstandings, and dissatisfactions.

Literature Review

A necessary first step is to turn to the literature in an attempt to discover whether any satisfactory solutions to the issue of loyalty conflicts have already been developed. The current review focuses primarily on the community psychology literature; however, it is very likely that the positions discussed will be representative of other community mental health disciplines as well.

Appropriate roles

The early 70's saw a lot of discussion about appropriate roles for the community-based mental health worker. According to Klein (1971), a basic role is to help shape the community to meet the needs of the individual; this requires a shift from "mental disorder ideology" to the promotion of mental health. Similarly, Glidewell (1971) supported the concept of community-based interventions, while Kelly (1971) noted that the community mental health worker needed an ability both to assess the community and to teach professional skills to the "host community, thereby returning the skill to the locale."

In a landmark paper, Meyers et al. (1974) based their discussion of appropriate roles on the recognition that the behaviour of an individual can be affected by a wide variety of interrelating environmental factors. Consequently, these authors recommend a "behavioural-preventive approach" to community mental health, wherein the primary goal of the mental health worker is to help develop and maintain a "self-controlling community," one which would be responsible to, as well as for, its members. This type of enriching environment would not be achieved by the imposition of externally based organizational programs. Rather, it would be the responsibility of the rural community mental health worker to transfer skills in such a way that the community and its members will be able to assume more responsibility for both individual and community growth. The Meyers paper clearly implies that the rural community mental health worker is an agent of change for the community. Therefore the focus, intent, and purpose of any intervention should be oriented toward local community needs; based within the community; developed within the community; and, finally, maintained by the community.

In a similar fashion, Jason (1977) has suggested that the community mental health worker needs to understand the effects of environmental influences on people, and that environmental manipulations should be included in any community-based intervention. Such a model would emphasize prevention, and would entail a re-orientation from mental illness to mental health reinforcers. There would be an emphasis on environmental rather than individual interventions; this would require a broader range of services. Again, the implication is that professional loyalties lie within the community. Jason does caution, however, that we must not allow these loyalties to be misused by special interest groups whose goals may not involve the development of self-controlling communities. Furthermore, as political decisions often determine community action, it is imperative that rural community mental health workers learn to use, and not be used by, this particular system. Unfortunately, identifying the antecedents of political decision-making and then acting accordingly requires skills which most of us have not yet acquired.

Identifying and meeting needs

One of the more appealing features of rural community mental health work is the latitude we have in identifying and meeting community needs. I am sure that all of us have been involved in some rather creative projects which were both necessary and appropriate for our particular communities. I am equally sure that the majority of us received no formal academic training which recognized that this would be an integral part of our professional activities. While this creative aspect of rural community mental health activities is appealing, we must also recognize that there can be serious limitations in terms of the reliability or transferability of our activities. For example, there's generally little cohesion, co-ordination, or integration amongst isolated mental health workers in terms of sharing or repeating their successful programs. This point has been recognized in the literature, and Fawcett et al. (1980), have suggested that it will become necessary for us to develop "replicable methods for solving community problems" as part of our efforts to help the communities assume more self-responsibility. According to these authors, if the rural community mental health worker is to function as change agent, it will be necessary to develop transferable methodologies in addition to enabling the communities to reduce their dependency on outside change agents.

Acker (1980) has suggested a rather intriguing model by which community mental health workers can help communities decrease their reliance on outside change agents. This model is based on the premise that behavioural community problems are interactive and everyone involved in any particular chain of behaviour that has been identified as a community problem actively participates in either maintaining that problem or providing the contingencies which could reinforce more adaptive types of behaviours. If this is the case, then, all participants would not be hierarchically related as is commonly the case in community consultations. Instead, all would function as co-researchers, mutually engaged in "functional analyses of the problems" that bring them together. Under this model, the community mental health worker is truly part of the community and there should be no loyalty conflict issue -- unless, of course, these "co-researchers" engage in activities that are not congruent with the programs and priorities of the organization that funds the mental health worker. In such a case, the funding organization might perceive a loyalty conflict issue even if the local community and community mental health worker did not.

Recently, our Centre participated in a community research project that closely followed Acker's model. This was a very stimulating experience for all, and provided a functional role for the lay members of this project. Unfortunately, the results of our research suggested priorities and areas of change that were not at all consistent with Provincial mental health guidelines, and once again I found myself assuming the "pushme-pullyu" stance in analyzing the locus of my professional loyalties and responsibilities. We will return to this local example later.

"Marginality" vs. allegiance

So far, the literature review has strongly implied that the community mental health worker should be functioning as an agent of change in the community -- with the community -- and for the community. There are, however, reports in the literature which do not support this position. For example, Silverman (1978), identifies the mandate of community psychology as the promotion of the "psychological well being of people in the system" with the goal of creating a "sense of community" as well as "maximizing the opportunity for social sharing and positive self development." These statements are clearly consistent with the philosophies already discussed. However, Silverman goes on to suggest that we, as change agents, have several role characteristics that may serve to isolate or insulate us from the community. For example, "marginality" refers to the distance a change agent should keep from the host community, as it will "never accept this individual as a native." Further, the community mental health worker will "function as a stranger separate from personal ties but free of local customs and allegiances." I doubt that many rural community mental health workers would accept these statements as either valid or appropriate. Being free of local customs and allegiances may be a realistic stance for theoreticians, but for the applied practitioner, a sense of identity and allegiance to local customs and priorities is often a defining characteristic of rural community mental health work. Moreover, especially in the smaller communities, the rural community mental health worker is frequently accepted as "native." Although it is certainly necessary to maintain some psychological distance from the local social networks in order to maintain a systems perspective, this can be done through a sense of professionalism without having to adopt the concept of marginality. As discussed previously, the concepts of the "self-controlling community" or the "community of co-researchers" places the community mental health worker in a shared role rather than as actual agent of change. In this context, the emotional distance between the mental health worker and the community becomes somewhat irrelevant. On the other hand, a recent study by Atkinson (1978), examining the varying influences community groups can have on a community mental health worker, suggests that the local mental health worker is exposed to (and perhaps susceptible to) pressure groups that may not reflect actual community needs. As a related concern, I think we also need to examine the possibility that the parent organization, in addition to the local community pressure group, may place idiosyncratic demands on the local community mental health worker. When this occurs, the local worker is once again faced with determining which squeaky wheel gets the grease. We seem to stand with a foot in both camps; this, I feel, can and will give us problems. Obviously, it is beyond the scope of this paper to resolve these issues and the intent is merely to generate further discussion.

Social validation

Our reality is that we do function within our communities and work toward making them better places to live. How then do we identify and evaluate community needs in order to help the community develop its own strategies for necessary interventions? Can we clarify loyalty conflicts that may arise?

Wolfe (1978) has elaborated the concept of "social validation" as an integral part of a community mental health worker's role when engaged in group, organizational, or community level interventions. According to Wolfe, social validation is based on three dimensions: 1) social significance of the goals (Are these goals what society wants?); 2) social appropriateness of the goals (Do the participants consider the procedures appropriate for the problem and the setting?); and 3) social importance of the effects of the intervention (Are the consumers satisfied with the program?) These dimensions, of course, involve subjective data; however, Wolfe contends that we should be able to systematize social validation techniques in order to increase our effectiveness as community mental health workers.

Mental health or social control?

So far the picture we have drawn of the community mental health worker is that of one who works for the best interest of the local community and the individuals within that community. I am sure that all of us, as rural community mental health workers, see ourselves as being good for the community and doing good for the community. However, reality may not be that simple. Szasz (1972), for example, has been warning us for years about the potential of the mental health movement to function in terms of social deviance control rather than in terms of the mental health of the individual or community. Szasz and others contend that this places the community mental health worker in the camp of the social controllers rather than with the local host community. These critics argue that mental health professionals tend to be a socially conservative force, in that deviancy typically is defined in terms of majority values. The consequence is that deviants generally are adjusted to fit the existing social environment, with little effort being expended in determining whether that environment is providing an inadequate support system. Szasz has been dismissed by many as a gadfly, yet I feel he has performed a very necessary service in reminding us to be aware of, and to examine closely, our systems of professional ethics and how they fit with the needs of our communities and our clients. For those of you who are content that your ethical system is intact I suggest that you periodically read these articles in the following order: "The Myth of Mental Illness" (Szasz, 1960); "Mental Illness Is not A Myth" (Ausebel, 1961); and "On Being Sane in Insane Places" (Rosenhan 1973).

Who is the client?

A critical element in the determination of professional loyalties involves the proper identification of the actual client. Stolz (1978), states that when a mental health worker is employed by a formal organization, the client will be that particular agency while the targets will be individuals being seen for treatment. Stolz also argues that mental health workers employed by agencies are under particular pressure to define the goals of intervention in terms of accepted social values and then to adapt our targets to that existing environment. Similarly, Holland (1978), also notes that the mental health worker's client is the individual or organization paying the bills. According to Holland, mental health workers employed by an agency cannot avoid having that agency as the client regardless of the extent to which the target individual or community may be involved in decisions about the goal and means of the intervention. These are interesting points to mull over as I suspect that most of us have not been identifying our employing agencies as "client." If that is the case, then loyalty conflicts become more understandable and it is easy to see that these conflicts might occur with some regularity in community practice.

Social responsibility

Few would disagree that social responsibility is an essential element to community mental health functions. Newbrough (1980) has operationalized the social responsibility of the community mental health worker as follows:

a) maintaining technical competence;
b) providing community services without compensation;
c) adapting services to special social or cultural needs;
d) applying professional expertise to pressing social or community problems;
e) participating in internal advocacy or social action on behalf of the client;
f) refusing to co-operate with institutions or individuals engaging in unethical practices;
g) exposing unjust or inhumane practices.

These are useful guidelines. However, I think that we cannot naïvely assume that these guidelines will always be acceptable to the "target," the community mental health worker, and the funding organization. What, for example, are we supposed to do if our parent bodies do not expect that "adapting services to special social or cultural needs" or "applying professional expertise to pressing social or community problems" are necessary or appropriate actions for agency employees? What do we do when, on behalf of our local communities, we participate in "internal advocacy or social action" and there are no resultant agency policy shifts? The planners within the parent agency may very well see such actions in terms of loyalty conflicts; in such situations we are left without pragmatic or definitive guidelines for further action.

A British Columbia example: the Cumming Report

A concern about loyalty conflict issues is not idle speculation or merely grist for academic mills, as this type of situation has occurred in British Columbia. In recent years the B.C. Health Ministry has undergone a number of reorganizations, each of which included a re-identification of appropriate community mental health priorities and programs. The so-called Cumming Report of 1979 formed a basic part of one of these re-organizational plans. This report was based on a year-long survey of Provincial mental health services and was supposed to represent an analysis and evaluation of existing mental health services. The final product, however, basically reflected the impressions and expectations outlined in the preliminary statements issued prior to the actual implementation of the formal survey. Rather than a methodologically sound analysis the final report therefore more closely resembled a special interest position paper. Briefly, the significant recommendations of this report were that the major responsibilities of the community mental health centres should focus on the care of the chronically disabled and the acutely ill. The Cumming Report suggested that children and family problems fell within the domain of other community resources. The community mental health centres were then characterized as competing with these other, presumably existent and available, community agencies. These assertions came as a complete surprise to most rural community mental health workers in B.C. who are familiar with resource scarcity but have yet to face the problem of client scarcity. Finally, the Cumming Report dismissed the inclusion of adjustment problems in mental health centre caseloads, the rationale being that these types of problem involved "frivolous and exotic treatments" and represented merely the interests of the primarily non-medical professionals and not the needs of the community.

This Report elicited a great number of negative responses from British Columbia mental health professionals. Upon the invitation of the British Columbia Health Ministry, the British Columbia Psychological Association reviewed the Cumming Report and concluded that it had "failed to meet even the most rudimentary criterion of objective reporting let alone scientific investigation." A similar analysis was delivered by the Association of Professional Social Workers of British Columbia. Nevertheless, the Ministry soon released priorities in mental health which reflected the basic orientations of the Cumming Report.

Interestingly, two other community mental health needs surveys were being conducted during this span of time; both of which more closely followed accepted research methodology. One was a province-wide survey which had been commissioned by the British Columbia division of the Canadian Mental Health Association, and the other was a local survey I conducted within my health centre catchment region. The results of these two surveys correlated highly and were completely at variance with the recommendations of the Cumming Report. As social validation exercises, both the CMHA's and my survey indicated that the priorities of the local populations were not in agreement with governmental priorities. Remember that we earlier discussed the concept of consumer satisfaction as one component of social validation. It would be unwise to assert categorically that these two surveys are more valid because, as Kazdin (1977), has cautioned, the functional utility of social validation exercises might be limited by a reliance "on non-professionals for determining treatment focus." However, similar cautions might also be voiced about a reliance on professional reports which may not be based on professional research methodologies. Regardless of the source of the recommendations, it can be logically expected that when a program is not seen by the consumers as necessary or appropriate, the continued and practical success of that program will be in jeopardy. Furthermore, if local consumers of these services do not support the intervention, it must be maintained by outside resources and this is not consistent with the goals of community mental health practices as reviewed in this paper.

The basic question still to be resolved is as follows: If the community mental health centre is involved with socially important problems at the community level; and if social validation techniques provide a means of evaluating the social acceptability of social service programs; and if this process indicates that the general population does not agree with the agency policy planners; then, what is the necessary and appropriate role of the local community mental health worker? I think this British Columbian example illustrates the possible dilemmas which may confront community mental health workers involved in community-level interventions. If, in the present example, I implement provincial priorities, then the local population may soon realize that participating in social planning surveys will have little or no impact on the definition or implementation of local services. In other words, they will soon come to realize that community participation in the determination of local community needs is inconsequential in terms of provincial planning and programming. If this occurs, it is my impression that the local mental health workers will lose credibility as community change agents. Furthermore, the implemented programs may not be easily integrated in the community and thus will function as externally imposed rather than integral parts of community resources.

On the other hand, if it is the social responsibility of the community mental health worker to become active in the social change process when social validation efforts illuminate discrepancies between local and governmental expectations, then we may, to paraphrase Holland (1978), soon face a withdrawal of positive reinforcement from the controlling system. In other words, we might lose our jobs.

Conclusion

Who does the rural community mental health worker support when the expectations of the social controlling system and the consumers of the services provided by that system differ? Can we develop a pragmatic model for resolving such loyalty dilemmas? Can we do more to operationalize the ethical and professional responsibilities of the rural community mental health worker when confronted with a lack of congruence between community and organizational expectations? I hope that this paper will generate further discussions in these areas.

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BUREAUCRATIC ISSUES FROM A COMMUNITY MENTAL HEALTH PERSPECTIVE

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ABSTRACT

In bureaucracies, personal satisfaction is often forfeited for government efficiency. Bureaucracy is concerned with means, society is concerned with ends, and somewhere in between we most often find the community mental health worker. The author identifies 6 major bureaucratic issues which potentially create moral and ethical conflict for the rural mental health worker. The article ends on a light note with a poem describing how bureaucracy maintains the status quo. Personal characteristics needed to survive bureaucratic situations include: (1) sense of humour, (2) persistence and (3) foresight.

Introduction

I will begin this paper by briefly summarizing some of the more formal points of view vis-a-vis bureaucracies and bureaucratic issues. I would then like to provide you with a more informal and more personal viewpoint. A workshop on this topic should probably begin with an open discussion of participants' experiences with bureaucracies and finish with recommendations for resolving various bureaucratic issues.

Historically, bureaucracies and bureaucratic issues have been around for a long time and the following statement by Petronius Arbiter in 210 B.C. exemplifies a bureaucratic issue that we are all familiar with today. "We trained very hard...but it seemed that every time we were organized to form up into teams, we would be reorganized. I was to learn, later in life, that we tend to meet any new situation by reorganizing: and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralization."

However, it was not until the late 18th and early 19th centuries that scholars and other interested authors began to write about the bureaucracy and attempted to explain why bureaucracies were formed and how they worked. One of the most prolific early writers on the bureaucracy was Max Weber; in more recent years both Robert Merton and Talcott Parsons have written extensively about bureaucracies, their social structure and their various functions in modern society.

Definitions

I would like to offer you now some of the more common definitions of the term bureaucracy, some of which may be more appealing to you than others. The first is by Max Weber; "Bureaucracy constitutes the creation of a new world of human interaction. In normal human life people relate to one another primarily through the meaning each attaches to his or her actions. The bureaucrat, on the other hand, is restricted to those actions that his work rules permit him and that fall within the scope of his jurisdiction. Hence, bureaucracy is the means of transforming social action into rationally organized action." A definition by Peter Blau is as follows: "Bureaucracy is an organization that maximizes efficiency in administration." Marshall Dimock defines bureaucracy as "composite institutional manifestations which tend towards inflexibility and depersonalization," while Edward Strauss identifies it as "the many imperfections in the structure and functioning of big organizations. The symptoms of bureaucracy include over-devotion to precedent, lack of initiative, procrastination, proliferation of forms, duplication of effort and departmentalism." James Boren, a man who has written satirically about the bureaucracy on many occasions, defines it in the following way: "Bureaucracy is not the domain of any particular group or institution, neither is it simply a collection of techniques and procedures. Bureaucracy is a way of life!" Finally, Webster's New Twentieth Century Dictionary defines bureaucracy as "the administration of government through departments and subdivisions managed by sets of officials following an inflexible routine."

Whatever your preference, it seems to me that most of these definitions are not particularly complimentary; and yet I think it is important to consider whether, in large organizations, there are alternatives to bureaucratic structure. In the final analysis it appears to me that all organizations must be structured in one way or another in order to avoid chaos or such a high level of disorganization that efficiency and productivity decrease to the point where the organization becomes figuratively or literally bankrupt.

What may we consider to be the major goals and objectives of the bureaucracy? Broadly speaking, I think they can be reduced to three: (1) the achievement and maintenance of control; (2) the achievement and maintenance of efficiency; (3) the achievement and maintenance of the bureaucratic system (survival of the status quo). In line with these three major goals or imperatives, as they are often called, is a set of elements or components that Anthony Downs (1967) has described as follows: "All bureaucracies have the following elements in common: (1) a hierarchical structure of formal authority; (2) hierarchical formal communication networks; (3) extensive systems of formal rules; (4) an informal stucture of authority; (5) informal and personal communications networks; (6) formal impersonality of operation; (7) intensive personal loyalty and personal involvement among officials, particularly in the highest ranks."

Major issues

With those particular elements in mind, let me now attempt to determine what, from a community mental health perspective, the major bureaucratic issues may be, always with the proviso, of course, that my own thinking on the matter is obviously subject to considerable personal bias acquired through previous learning experiences. The first issue to consider is one in which personal satisfaction based on mastery over one's own work conflicts with efficiency, as seen from a centralized managerial viewpoint. Within mental health services, it has been my experience that this conflict is usually between those people responsible for the delivery of the services in a specific community or region and those people in middle or senior management positions located in the provincial capital. A second particular issue has to do with the fact that a bureaucracy's concern is with means, while society is primarily concerned with ends; these two separate concerns produce a conflict between the need for control and the need for service. From society's point of view, the public service was essentially created to provide services; from the bureaucracy's point of view, however, control is the inner imperative. Thus, the tendency of any bureaucracy is to substitute inner control for outward service. In mental health services, this conflict is most apparent between the community's ever-increasing demands for service and the bureaucracy's ever increasing demands for cost control. As most of us have frequently experienced, the professional and clinical mental health worker is caught between these two demands. A third bureaucratic issue is the one which pits worker efficiency against worker effectiveness. For the bureaucracy, efficiency means following the rules and providing a service at the least cost; for society the effectiveness (and availability) of the service in meeting human needs is of paramount importance. I believe evidence for this conflict in mental health services can be seen when the bureaucracy measures efficiency in terms of the number of people seen at the lowest possible cost, regardless of whether the services received were effective in either meeting human needs or significantly changing human behaviour.

A fourth conflict frequently occurs between human needs and bureaucratic system needs. This conflict may be reflected both internally and externally. Internally it is seen whenever an employee needs to deviate from the rules of the organization. In mental health, a good example of this, until the rules were finally changed, was that no staff member could work outside of regular hours without senior managerial permission- a rule that made the delivery of emergency mental health services and crisis intervention services after office hours virtually impossible. An external example, which has recently occurred within our own community, is the managerial decision to transfer clients in receipt of homemaker services from one agency to another without any apparent regard for the needs of each particular client.

A fifth bureaucratic issue is the maintenance of the status quo versus the need for flexibility and adaptability. In many ways the bureaucracy is an organization that cannot (or will not) correct its own behaviour by learning from its errors. For example, in our own Health Ministry there have existed for the last eight years two separate funding systems for staff positions in Community Mental Health services. One of these funding systems is operated by Hospital Programs while the other is the responsibility of Community Health Programs. Despite the fact that these two separate mental health outpatient services create fragmentation and client confusion at the community level, these two parallel systems of funding continue to operate, simply because they belong to two separate bureaucratic divisions within the Ministry.

The final issue, and to me one of the most important ones, is the issue of who evaluates the evaluators. In other words, who assesses the competency and accountability of the people in the bureaucracy who have the power? As the tendency towards centralized bureaucracies continues, this issue becomes increasingly significant, particularly in view of the fact that most senior middle managers, Treasury Board staff personnel and various executive directors usually have no training, experience, or specific expertise in the actual delivery of community mental health services.

Dealing with the bureaucracy

If the bureaucracy is here to stay, and I firmly believe that it is, what steps can be taken to counteract the increasing power of centralized bureaucracies? At a formal and perhaps academic level two counteracting forces have been proposed; the first is the creation or the use of existing countervailing bureaucracies; these bureaucracies would include trade and technical unions, professional organizations, municipal and regional governments and non-profit social and community organizations. The second counteracting force proposed would consist of such things as independent review committees, an office of administrative procedures, government Ombudsmen and congressional committees similar to those which have been created in the United States. To me the major flaw in these countervailing forces is that they are in themselves separate organizations, which over time have the potential to become just as bureaucratic as the bureaucracies they have been formed to counteract.

Let me end with some of my own personal strategies for dealing with the bureaucracy. First, I think it is very important to identify correctly which bureaucrats within the organization one has to deal with. Once one is able to contact the actual bureaucrat with the power to change things it is often possible to bring about a successful resolution to a problem. The second useful strategy is to find out who inside the bureaucracy are the expediters. Frequently, I have found the most successful expediters to be clerical support staff, technicians, or other non-management personnel who seem to be more concerned with getting a job done than in preserving the status quo.

If, for a variety of reasons, you have decided to take on the bureaucracy with regard to a particular community issue, I believe that it is of fundamental importance to do your homework on the issue involved. By that I mean you must be extremely knowledgeable about all aspects of the issue, including not only the human needs factors but also the cost-effectiveness factors.

There are two other strategies you may at times find useful to employ in dealing with the bureaucracy. One is to involve local support groups; these may be citizens' groups, local non-profit organizations or advisory committees to specific programs. At times such support groups can be helpful in breaking bureaucratic red tape. The second group of people who may assist you in resolving a particular local issue is the municipal or regional council. Sometimes these elected representatives can have access to senior decision makers and can actually bring about change at a significantly faster rate than going through the usual bureaucratic channels.

Finally, what personal characteristics are essential for surviving the bureaucracy and bureaucratic game-playing? In my own experience it is very important to be open, honest and persistent in one's request for change or the resolution of specific issues; it also helps enormously to have a sense of humour and to be able to see the "funny side" of the many maneuvers employed by bureaucrats to preserve the status quo.

To end this article on a lighter note I would like to quote a delightful poem written by James Boren in 1976 in his book The Bureaucratic Zoo:

"Let's orchestrate and dialogue
In words that we adore,
The words that we all mumbled
A million times or more.

Let's shuffle all our paper,
And fuzzify our minds;
Let's wrap our brains in cobwebs.
And love red tape that binds.

Let's regulate the people
With rules, reports, and forms;
Inspire true innovation
As long as it conforms.

Let's optimize the status quo,
And sit right where we are,
For if we keep our profile low,
We'll get no battle scar.

Let's cut our red tape lengthwise,
Profundicate our words,
And build great stacks of paper,
The stuff that undergirds.

Yes, let's fingertap together
In a dedicated way,

And postpone all decisions
Until another day."

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DEVELOPMENT OF A VOLUNTEER PROGRAM FOR USE IN RURAL MENTAL HEALTH CENTRES: THE CARIBOO MODEL

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Mercedes Finnegan - Williams Lake Crisis and Counselling Centre
Jeffrey Dinsdale - Quesnel Mental Health Centre
Dorothy Wheeler - Quesnel Crisis Line and Centre

ABSTRACT

It is both important and necessary to use volunteers to supplement the professional mental health services in rural communities. The identification of the need for such a program must spring from the community but should be nurtured by the Mental Health Branch staff. Using the Cariboo model as an example, the article addresses the following issues:

1) The nature of the communities in which a volunteer program is viable.

2) The rationale for using volunteers in rural mental health centres.

3) What do volunteers do?

4) How the program is administered.

5) Recruitment, training and supervision of volunteers.

6) History and evaluation of the Cariboo Volunteer program.

Because of space limitations, only the program in Quesnel, B.C. (population 10,000) is discussed in detail, although a similar program is also operating successfully in Williams Lake.

1. THE NATURE OF THE COMMUNITY: AREAS FOR WHICH THIS PROGRAM IS RELEVANT

Smaller towns and cities (population approximately 5,000 to 70,000 people) with many of the following characteristics:

- Very few private non-governmental social services in existence.
- Government-sponsored services usually intact, comprising social welfare, public health, corrections, and mental health programs. These services are usually small and tend to be non-specialized. Very often they are sub-offices of a larger centre, with decision-making powers lying elsewhere.

- Communities are often one-industry communities, often relying heavily on resource development; they may even be "company towns."
- Population tends to be younger, more mobile, working-class.
- Problem areas usually include alcohol abuse, marital problems, violence, child- and family-related issues.
- There is a community awareness of the social needs that exist in the community.
- There exists a certain "cohesiveness" in the community, a readily identifiable service area, and a pool of resource people from which to draw volunteers.
- There exists the opportunity for training and ongoing supervision of volunteers.

2. RATIONALE: WHY VOLUNTEERS IN RURAL MENTAL HEALTH CENTRES?

- Volunteers are members of the community, more aware of community needs; involving them also increases the accountability of programs.
- Volunteers, as members of the community, relate better to and understand the needs of their fellow citizens.
- Political effectiveness: a grass roots movement composed of members of the community, not paid government officials, carries much more political clout.
- Volunteers represent a vast source of untapped energy.
- Volunteers are cost effective -- a key advantage in times of constraint. They permit the development and operation of programs that could not be offered using paid government employees.

DISADVANTAGES OF USING VOLUNTEERS

- Lack of training: therefore a need to develop a training program.
- Lack of professional identity.
- Constant turn-over in volunteer population: therefore a need for ongoing training programs.
- Need for constant direction, organization, and supervision, all of which is very time-consuming.

3. VOLUNTEER DUTIES

The Quesnel Model

1) Crisis Line Program

- Volunteers cover nine shifts a week in their homes. Each volunteer is asked to be available, if possible, for two shifts a month. The crisis calls are received by an answering service that is able to "patch" each call directly to the "on duty" volunteer's home.
- Volunteers are booked for shifts by the Program Director at the beginning of each week.
- Volunteers are expected to keep a record on paper of each call and mail or bring the intake sheets to the office.
- The volunteers are called after each shift and asked for a short verbal report so that the Director can be made aware of calls, and alert the next shift worker if necessary.

2) The Daily Hello Program

- This program was initiated to offer ongoing support by telephone to people needing contact on a daily basis.
- A volunteer is assigned to each "Daily Hello" client (with the written consent of the client). The volunteer is then committed to call each day for as long as it is beneficial to the client.

3) Crisis Line Counselling Program

(a) Face-to-face Counselling Program

- The Crisis Line Counselling Program was originated in 1979 by the Mental Health Team in conjunction with the Crisis Line.
- The program was developed to increase the effectiveness of the Mental Health Team by using trained Crisis Line volunteers to do face-to-face supportive counselling and crisis intervention.
- The Mental Health Team is responsible for the training of these lay counsellors.
- Supervision of counsellors is the responsibility of the Program Director.

When clients are referred from the Mental Health Centre to the Crisis Line, the Program Director will choose a suitable counsellor for the client; the counsellor will then submit regular reports to the Director. If problems arise, the Mental Health Team may be consulted.

- Clients are also referred for face-to-face counselling directly through the Crisis Line staff and volunteers, with the same supervision applying.
- Most counsellors in this program are established Crisis Line volunteers.
- An extensive 12-week, 35-hour course must be completed before a volunteer is qualified to be in the counselling program. The instructors for the course are the Mental Health staff.
- Counsellors are asked to give the client one hour a week, or more if possible.
- The duration of time that the counsellor will remain with the client is decided by the counsellor, the Director and the client.

b) Crisis Line Standby

- All Crisis Line shifts taken at home by volunteers are also covered by a standby (person with counsellor training) who is available to the line worker for consultation and advice.
- The standby will take calls when the volunteer line worker has a busy line, and will fill in if the line worker cannot cover the shift.
- It is the responsibility of the standby to find a replacement if he or she cannot cover the shift.
- The standby (or the Director) is responsible for sending out the Flying Squad.

c) Crisis Line Flying Squad

- Counsellors are asked to serve as members of the Flying Squad. Squad members will respond in person to a call in their area, if possible, when asked by a standby counsellor or the Director. Two volunteer counsellors are sent on each call.
- Both counsellors are responsible for making a full report on the call, as is the crisisline worker who received the call.

Statistics

- In the first 8 months of 1981, 14 counsellors were sent on seven Flying squad calls (e.g. suicide threats, family violence).
- As of September, 1981, the face-to-face Counselling Program has been in effect for 18 months; 15 clients have been placed with volunteer counsellors to date.

- Each counsellor who was an active Crisis Line standby person gave over 1,000 hours to the line in the first 8 months of 1981.
- Volunteers took 245 calls at home.
- The office received 124 crisis calls and 536 information and volunteer-related calls.
- As of September 1981 there were five line workers giving a "Daily Hello" to five clients.

4. Activities Centre Program

- The doors of the Centre opened on March 2nd of this year, with sessions every Monday, Wednesday and Friday afternoon from 1:00 p.m. to 4:00 p.m.
- The Centre offers resocialization and ongoing support to members of the community who have mental and emotional problems, and/or physical disabilities. They are referred from various agencies and professional people in the area.
- The Centre people participate in group activities, discussions and outings, the purpose being to gain social life skills in a friendly and supportive group atmosphere.
- The Centre is supervised by the Crisis Line Program Director.
- Each Centre session is supervised by the Director and by two volunteer counsellors. Other volunteer helpers come regularly also.
- Volunteers supervising the Centre come from the group of trained Crisis Line counsellors and give one or two afternoons a week to the Program. These trained counsellors, and the Director, recruit and advise other volunteer helpers.
- Centre volunteers do not counsel persons individually during Centre sessions, but maintain a group situation, encouraging participation in group discussions and activities.
- Volunteers encourage Centre people to help plan, prepare and carry out all Centre activities.
- There are six volunteer counsellors and helpers supervising regularly assigned Centre sessions; two volunteers attend all sessions (nine hours a week) and four attend one session (three hours a week).
- It is hoped that very soon a co-ordinator will be hired for the Activity Centre. The duties of this staff person will be:

  - To expand the Centre's activity program.
  - To make home visits to new people referred to the Centre, and visits to encourage people to continue to attend.
  - To transport people to the Centre when necessary, especially new clients.
  - To work with the program Director to supervise, improve and expand the Centre.

- The next step will be to increase the Centre hours from nine to 15 hours a week by opening every weekday afternoon.

4. ADMINISTRATION OF A VOLUNTEER PROGRAM

Quesnel Crisis Line

- The Crisis Line is one of three programs of the Quesnel Contact Line and Centre Society, and is under the supervision of the Society's Board of Directors. This society also administers Child Care Workers and Homemaker Programs with a total combined budget of over $400,000.00 per annum.
- The Crisis Line has served the Quesnel community 24 hours a day, seven days a week for 10 years.
- At present there are 24 active Crisis Line Volunteers.

Staff

- Office Manager; responsible for the office management of all programs of the Quesnel Contact Line and Centre Society.
- Program Director; working directly with volunteers in all Crisis Line Programs.

New Volunteers

- All new volunteers have a three-month trial period, at the end of which they will be evaluated by the administrators.
- All new volunteers are encouraged to be in close contact with the staff, by phone or at the office, during their initial period on the line.

Established Volunteers

- It is essential that all concerns be brought to the immediate attention of the administrators so that a solution may be worked out, with no disruption to the service.

- If a solution cannot be brought about, the Board of Directors is then consulted, in writing.

- It is necessary that there be a feeling of mutual respect and trust within the system (the volunteers, the staff and the Board of Directors).

Volunteer Recruitment and Training

- (Discussed in more detail in Section 6 below.) The responsibility of Program Director in conjunction with the Mental Health Centre staff.

Volunteer Morale

- It is most important that there be an amiable and supportive working relationship among the volunteers and the staff in order to ensure that the best possible service is being given to the community.

- Volunteers must be kept informed and up to date on all Crisis Line procedures and policies, and the importance of their part in the program must be made known to them.

- A newsletter is sent each month to volunteers to keep them informed on all matters.

- Each month a volunteer meeting is held and everyone is encouraged to attend. It is an opportunity to air problems and find solutions. It is also a time for old and new volunteers and staff to socialize.

Funding

Current fiscal year budget (Ministry of Human Resources funding):

- Salaries and benefits	$28,650.00
- Operating costs	6,655.00
- Total funding received	$35,305.00

Projected budget for the next fiscal year (Ministry of Human Resources funding):

- Salaries and benefits (including the request for a full time co-ordinator for the Crisis Line Activity Centre)	$47,997.00
- Operating Costs	9,500.00
- Total funding required	$57,497.00

Funding - Drop in Centre

- A grant of $2,000.00 was received from the Canadian Mental Health Association to initiate the Activity Centre Program.

- An application has been made to MHR for funding for another Crisis Line staff person to co-ordinate the Activity Centre. This application is for the fiscal year beginning in April, 1982.

- Application has been made to MHR for the Achievement Centre funding of $1.10 per person per hour attending the Activity Centre. This would begin the next fiscal year also.

- Other more immediate sources of funding are needed so the community businesses and service clubs have been approached; also the lotteries.

5. EVOLUTION OF VOLUNTEER PROGRAMS

- The support base for the volunteer program and the mental health centre springs from the community.

- The volunteer program often has its own independent focus separate from needs perceived by mental health centre.

- The volunteer program is an independent body with its own administration, funding, and board of directors.

- The marriage of mental health centre and volunteer organization results from shared goals and is based on extensive planning and clarification of roles.

- There can evolve formal administrative links between the two organizations, including shared funding, accommodation, board representation, and even administration.

- Funding is an ongoing headache. All sources of funding should be tapped.

Pitfalls to Avoid

- Make sure the communication between the mental health centre and the volunteer organization is open and constant. Do not rush this process.

- Don't overextend the volunteer organization, especially in terms of manpower resources and finances. It is important to do a limited program well rather than be over-ambitious and have programs fail.

- Volunteer morale is important.

- Don't allow the mental health centre professional to be in the position of running the volunteer program; that person simply won't have the necessary time or energy. The volunteer program should have its own separate administration.

- Develop a realistic ongoing training program.

- Choose the right people to run the program. The prime requisite should be an ability to relate to the volunteers.

- Don't allow the program to be too loosely structured; untrained volunteers need structure and direction. The screening process is important.

- Re-emphasize again the importance of ongoing and open communication between the mental health centre and the volunteer organization.

6. RECRUITMENT & TRAINING OF VOLUNTEERS

Quesnel

Recruitment

- Word of mouth

- Advertisements (public places, newspapers)

- Churches, community groups

- T.V. and radio

Volunteer Training

Orientation session in the Crisis Line office.

- A time for the prospective new volunteer to learn about the program.
- A time for the Program Director to evaluate and decide if the new person will be suited to the program.

A session with the established group of volunteers.

- Crisis Line procedures
- Basic listening skills
- Chronic callers
- Case histories
- Role playing

A session with the Mental Health Centre staff

- Defining a "crisis" and "crisis intervention"
- Depression
- Suicide
- Role playing

Ongoing training.

- Volunteers are encouraged to attend any workshops or seminars that pertain to mental health.

- Volunteers have a standing invitation to attend training sessions at the Prince George Crisis Centre.

- At each monthly volunteer meeting a person from the community will speak on a subject pertaining to mental health.

- All volunteers interested in becoming involved in other Crisis Line Programs (Face-to-face counselling) are offered an extensive 12-week training course at the Mental Health Centre.

Ongoing Training

- Regular staff meetings.
- Workshops on crisis intervention, stress, marital counselling.
- Ability to attend workshops in other communities.
- Reading and supervision.
- Introduction to other community agencies.
- Possibility for volunteers to progress to different areas if they become more competent.

After a period of six months with the Crisis and Counselling Centre, volunteers receive a certificate from C.M.H.A. to recognize their work and commitment.

VOLUNTEER TRAINING PROGRAM OUTLINE

1. Introduction/Attending

2. Communication Skills

3. Self- Awareness:
    - Examination of one's own values
    - Primary level of accurate empathy and genuineness
    - Expression of one's feelings; concreteness

4. Crisis Intervention

5. Problem Solving Skills
6. Stimulating the Client to Alternative Frames of Reference
7. First Interview (incl. Role Play)
8. Alcoholism: Treatment Centres; Process of Addiction; Support for Families of Alcoholics; Role Play

9,10. Suicide Intervention and Follow-up (incl. Role Play)

11. Introduction to the Centre

RECOMMENDATIONS

1. That the Ministry of Health, particularly Mental Health Programs, commit itself to ongoing funding of community-based volunteer programs and other support services.
2. That the Ministry of Health accept the model of integrating private community-based volunteer services into mental health centres, with formal administrative links and shared accommodation.
3. That the job description of the rural mental health professional specifically focus on the importance of providing support and back-up to lay people providing mental health services in the community.
4. That the rural mental health professional be encouraged to actively develop indigenous resources and sources of program support in the community, and that this be a recognized part of his/her job description.
5. That the provincial mental health department offer ongoing training and orientation to field staff on developing and fostering community-based volunteer programs in the field of mental health.

LIMIT-SETTING ISSUES - PROFESSIONAL SURVIVAL FOR THE SOLO MENTAL HEALTH WORKER

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ABSTRACT

This article addresses three main issues: (1) Why set limits? (2) What are the specific skills necessary to enable the mental health worker to set the limits? and (3) How do we determine where to "draw the line"? Dr. Stein identifies the key factors involved in answering these questions, underscoring that rural mental health workers must determine the parameters of their service provision based on (1) personal/professional competence, (2) community needs, and (3) resource groups. Finally, the article emphasizes the necessity of informing the community about exactly what services will be provided. Appended to the article (Appendix 1) is a document prepared by Dr. Stein for his Mental Health Centre which provides a model of how to inform your community about the mental health services provided by the mental health centre.

Workshop

Limit-setting is a relevant issue for rural mental health professionals because it is a potential stressor. The "Homeostatic" model of stress proposes that stress can be insufficient, optimal or excessive. Excessive or insufficient stress impairs performance.

Figure 1 summarizes the interface between stress and functioning across three domains: self, interpersonal, and community. Insufficient stress causes system underload which can result in "rust-out," aimlessness and job dissatisfaction; alienation and apathy; and the failure to meet community expectations. Excessive stress leads to system overload that causes "burnout," "workaholism," grandiose goals, "Type A" tendencies, and the inability to satisfy excessive community expectations. However, optimal stress results in maximum job performance; realistic and concrete goals; close personal and job relationships; and both realistic and attainable community demands.

Optimal functioning requires effective coping with stress. Coleman (1977) has suggested that stress management requires: (1) accurate appraisal of the stressor; (2) formulation of alternatives; (3) deciding and implementing a course of action; and (4) relying on feedback to determine your success or failure. Some reasons for ineffective coping are: inadequate information, poor use of time, oversimplification, and emotional and defensive reactions (Coleman, 1979).

The above suggests that it is necessary to possess certain skills in order to cope effectively with stressors, and thus be able to set limits. The specific skills which are useful include: time management (Lakein, 1973); goal setting (MacLean, Stuart & Wilson, 1980a); assertiveness (Fensteinheim & Baer, 1975; Smith, 1975); and Social Effectiveness (Hicks & Lillibridge, 1980; MacLean, et al., 1980b).

Without limit-setting, neither the community nor the professional will be satisfied. Moreover, the professional is apt to change roles constantly as exemplified by the Feiffer Cartoon. Limits define the relationship. They serve as reminders to the community of its responsibility to its residents, to the professional, and to their mutual relationship. Limits ultimately depend upon the "givens" of a situation.

It is these givens which must be identified before limit setting can occur. The following givens are factors which are essential to learn prior to limit-setting: (1) community needs; (2) community resources; (3) untapped resources; (4) job requirements; and (5) gaps in service.

The following course of action is recommended to obtain this information:

1. Conduct a formal needs assessment.

2. Meet formally with other social and health service personnel.

3. Meet with community groups.

4. Meet informally with non-professional personnel who may possess "untapped resources."

5. Develop and maintain an up-to-date community resource guide that is widely distributed.

6. Review job specifications and agency objectives.

7. In conjunction with other community groups and agencies, identify resource gaps.

The rural mental health professional should now be in a position to decide which services he/she will offer. This determination is based upon: (1) personal competences, (2) community needs and (3) resource gaps (which have been identified). Lastly, appropriate agencies and the community should be informed of what services will and will not be provided. (It may be necessary to annually review and revise the services offered.)

This will cause some disappointment, but you cannot be all things to all people. If you have carefully gone through the recommended procedure, your service will likely be perceived as necessary, desirable, visible and effective. What more could you ask for?

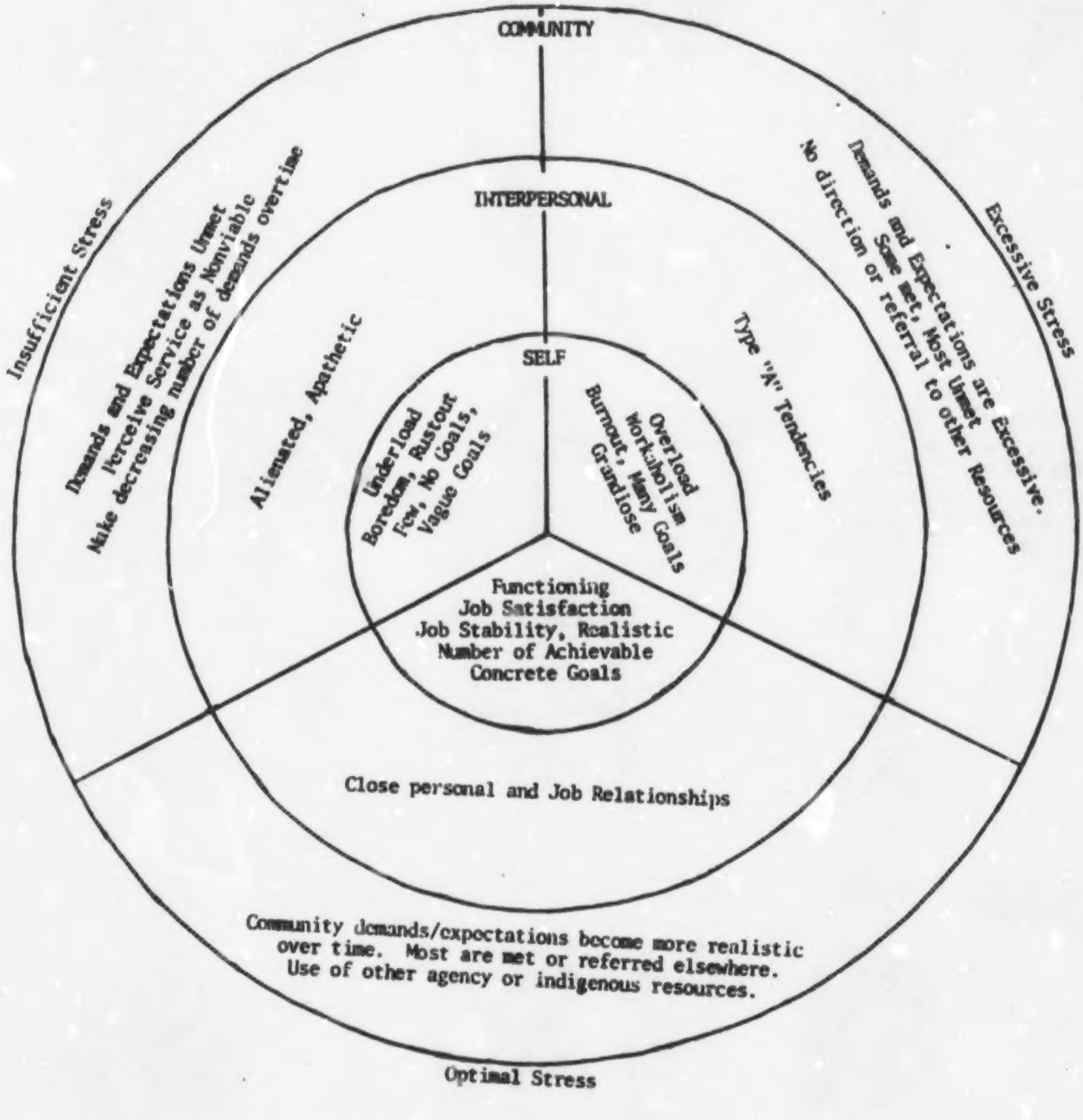
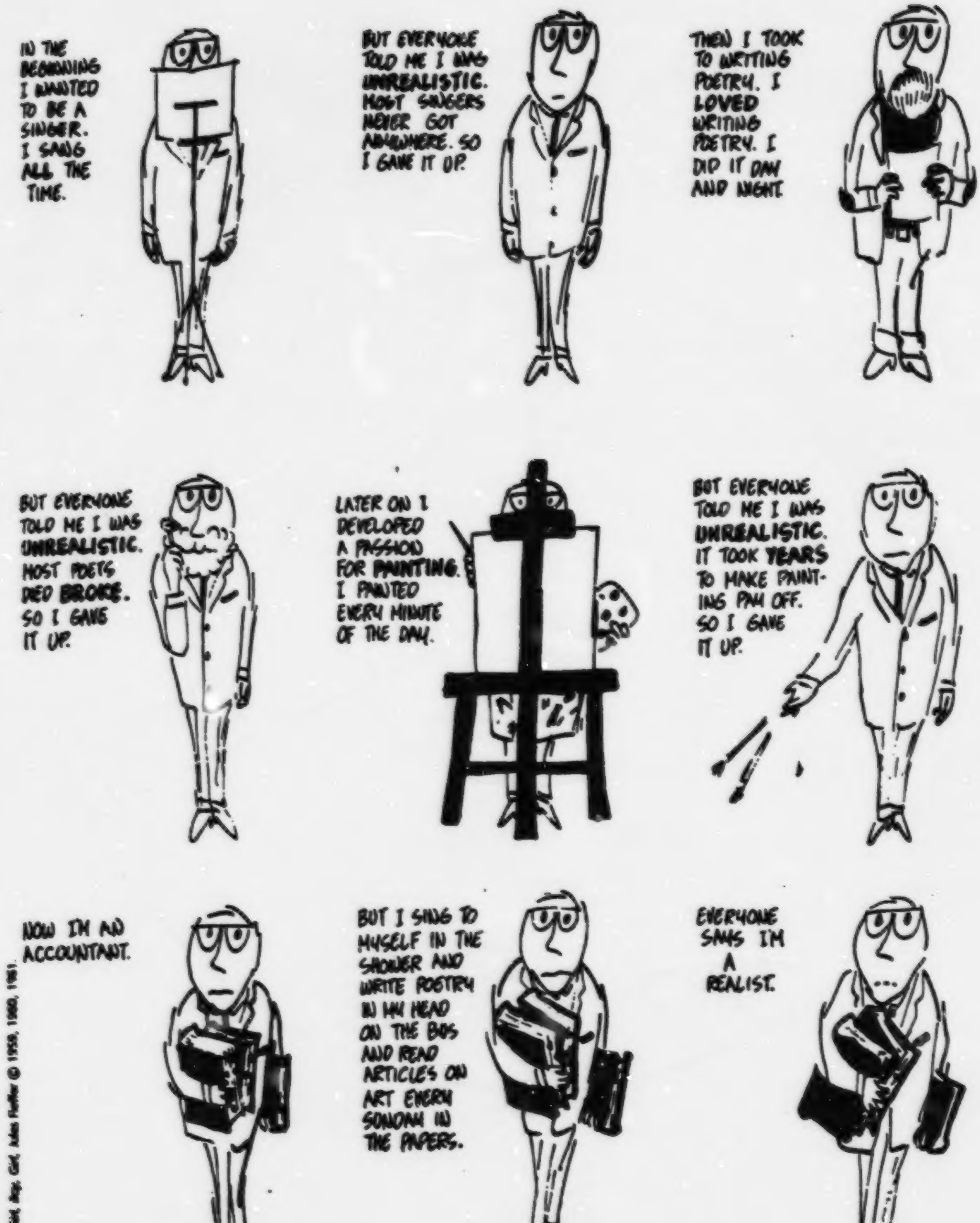

COMMUNITY
INTERPERSONAL
SELF
Insufficient Stress
Demands and Expectations Unmet
Perceive Service as Nonviable
Make decreasing number of demands overtime
Alienated, Apathetic
Underload
Boredom, Rustout
Few, No Goals,
Vague Goals
Excessive Stress
Demands and Expectations are Excessive.
Some met, Most Unmet
No direction or referral to other Resources
Type "A" Tendencies
Overload
Workaholism
Burnout, Many Goals
Grandiose
Functioning
Job Satisfaction
Job Stability, Realistic
Number of Achievable
Concrete Goals
Close personal and Job Relationships
Community demands/expectations become more realistic
over time. Most are met or referred elsewhere.
Use of other agency or indigenous resources.
Optimal Stress

Figure 1: **Levels of stress and their possible outcomes in 3 spheres: Self, Interpersonal and Community**


IN THE BEGINNING I WANTED TO BE A SINGER. I SANG ALL THE TIME.
BUT EVERYONE TOLD ME I WAS UNREALISTIC. MOST SINGERS NEVER GOT ANYWHERE. SO I GAVE IT UP.
THEN I TOOK TO WRITING POETRY. I LOVED WRITING POETRY. I DID IT DAY AND NIGHT.
BUT EVERYONE TOLD ME I WAS UNREALISTIC. MOST POETS DIED BROKE. SO I GAVE IT UP.
LATER ON I DEVELOPED A PASSION FOR PAINTING. I PAINTED EVERY MINUTE OF THE DAY.
BUT EVERYONE TOLD ME I WAS UNREALISTIC. IT TOOK YEARS TO MAKE PAINTING PAY OFF. SO I GAVE IT UP.
NOW I'M AN ACCOUNTANT.
BUT I SING TO MYSELF IN THE SHOWER AND WRITE POETRY IN MY HEAD ON THE BUS AND READ ARTICLES ON ART EVERY SUNDAY IN THE PAPERS.
EVERYONE SAYS I'M A REALIST.
From Boy, Girl, Boy, Girl, Jules Feiffer © 1959, 1960, 1961

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"LIMIT-SETTING ISSUES, "APPENDIX 1: SAMPLE DESCRIPTION OF SERVICES

Province of British Columbia
Ministry of Health
Mental Health Centre
Ambulance Building
Box 171
Port Hardy, B.C.
V0N 2P0

NORTH ISLAND MENTAL HEALTH CENTRE (update)
Effective September 1, 1981

Hours:	9:00 A.M. - 6:00 P.M.	Monday-Thursday
	7:00 P.M. - 10:00 P.M.	Tuesday

Phone: 949-8132

Present Staff: Dr. Barry M. Stein (Psychologist-Full Time)
Ms. Betty M. Evans (Secretary-Part Time)

For Appointments: Contact the centre Monday-Thursday in the mornings or Tuesday all day. (It is expected that Mondays will be spent visiting Port McNeil and Port Alice where evening appointments will also be available.

Fees: Since this is a provincially funded agency, there are no fees directly charged to the clients. Tax dollars pay for the services.

Current Services Provided - Individual sessions are approximately 45 minutes.

I. Psychological Assessment

A. Neuropsychological - Evaluation of the presence/absence of cerebral dysfunction using a battery of tests. Time constraints may allow for screening only. The service is available only to adults. Testing of children is available by referral to other agencies on Vancouver Island (e.g., Duncan) or on the lower mainland (e.g., Vancouver).

B. Personality (Three Sessions)-Evaluations of normal personality traits as well as psychological disorders. The service is available to both children and adults, and will require at least three hours of testing (minimum of two interviews).

C. Mental Status Exam (One or two sessions) - To evaluate the presence or absence of psychiatric disorders. This is available only by physician or court-ordered referral.

II. Therapy: Provided to help individuals cope better with their problems.

A. Individual

B. Self-Control/Stress Management: for stress-related disorders (hypertension, ulcers, etc.).

C. Marital and Family Therapy

The type of therapy is determined from the nature of the presenting problem.

III. Consultations

A. Interagency - Advice and recommendations to other government agencies offering services to the public.

B. Professionals & Organizations - Advice to professionals (e.g., physicians) on mental health issues is also available.

IV. Education & Workshops

A. Mental Health Services provides workshops for local communities. Speakers from other regions will be coming to the North Island this year.

B. Dr. Stein is working on a pilot project to coordinate the use of Life Style Self-Help modules developed by the Canadian Mental Health Association.

V. Services not being provided

A. Emergency after-hours service.

B. Preventive Services.

C. Psycho-educational testing.

D. Vocational Testing.

VI. Some typical problems treated at the centre include:

- A. Depression
- B. Anxiety (restlessness, sleep disturbances, etc.)
- C. Stress-related disorders
- D. Irrational fears, phobias
- E. Behavioural disorders and adjustment problems.
- F. Marital and family discord.
- G. Sexual disorders (including dysfunction)

For further clarification of services offered call Dr. Stein or Ms. Evans. It should be noted that the centre has a mandate to cover an area roughly corresponding to School District #85. With only one professional staff, clients cannot always be provided with immediate appointments. Appointments should be made prior to coming to the center. If you or someone you know might benefit from any of these services please contact the center. In most cases, you can expect a one-week waiting period before getting an appointment.

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SECTION THREE: "PROGRAM SURVIVAL"

Section Editor: J.L. Kyle, Ph.D.
Director, Mental Health Centre
Courtenay, British Columbia

NOTES ON PROGRAM SURVIVAL*

J.L. Kyle, Ph.D.
Director, Mental Health Centre
Courtenay, British Columbia

A Mental Health Conference attended by mental health policy planners and administrators, field-based professionals, and mental health volunteers offers a unique opportunity for a constructive examination of rural mental health programming concerns. The "Program Survival" section of this Conference addressed a spectrum of programming concerns, including the blending of political, economic, and professional demands into policy guidelines; the attempt by local professionals to transform those guidelines into community services; and the role of volunteers in ensuring that these services are both relevant and available. This section of the Handbook includes examples of field-based and field-initiated applied research; policy planning considerations; and examples of community-based programs. This blend of orientations allows us to take a broader look at the contraints and influencing factors facing those who are involved with rural mental health programs. It is hoped that the issues raised under this theme will stimulate us to look at the various ways in which each of us can become more effective in supporting the continued survival and enhancement of rural mental health programs.

If mental health workers want their programs to survive, they will be well advised to familiarize themselves with those factors which may influence policy planners and decision makers. According to Stan Remple, these factors might be operationalized as four basic "arenas": financial, political, socio-cultural, and organizational. In the ideal world, these realities would be mutually complementary and logic would prevail. Not surprisingly, Remple points out that this is not the case, and goes on to identify a host of components within these four realities which have differential -- and sometimes contradictory -- influences on the planners and policy makers.

Although self-described as only a pilot study, the work done by Alan Rendle clearly demonstrates the important role that local mental health centre staff should play in the evaluation of mental health programs and services. Rendle examined the relevance of the so-called five essential mental health services to rural areas. Although preliminary, his conclusions are interesting, and sometimes provocative. Rendle's demonstration of the research and evaluation expertise available at the local level is particularly compelling in British Columbia, where research traditionally has not been seen by "headquarters" as a very necessary role for the mental health centres to fufill.

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* Section Editor's Introduction.

Cameron identifies rural mental health program stability as being contingent upon five basic factors. The elaboration of the components within these five factors will provide a wealth of useful information for mental health centre directors evaluating their own programs. For example, Cameron lists several keys to the development and maintenance of successful community networks. Stability in a rural program also depends on how the community perceives the professional qualifications and identities of the various staff members. The matching of community and personal life-style expectations is another key to professional effectiveness. Cameron comments on the somewhat disruptive effect that the recent, and frequent, B.C. Health Ministry policy re-organizations have had on local program stability. We can only speculate what direction these re-organizations might have taken had it been expected that field staff would have more responsibility for applied research activities such as community profile analysis or program evaluation.

Thompson and Barr examine program stability in terms of the rather typical problem of attracting and keeping rural staff. Their analysis yields a number of important recommendations. For example, we should not relax clinical or professional standards when recruiting rural staff. It is also necessary that these staff receive more back-up and staff development opportunities. The recommendations listed are practical, feasible, and should be seriously considered by senior management as one means of attacking the chronic problem of recruiting and retaining qualified staff in rural areas.

Starting with Brown's neat little recipe for effective use of the media, the focus of this section then shifts to examples of local creativity in providing relevant community mental health services.

A unifying theme of the papers presented by Hutton, Rathwell & Hellon, and McIntyre is the absolute necessity that community mental health centres become a functional link in community networks, avoiding an "ivory tower" isolationist stance, if they are truly to function as a community resource. Rural mental health workers should acknowledge their professional expertise, but they cannot afford a stance of professional élitism. These papers clearly demonstrate the efficacy of a partnership of resource personnel in which the mental health centre staff are a necessary component, but not necessarily the only "experts."

Devlin's presentation reminds us to be sensitive to the possible adverse program consequences of misunderstanding or ignoring differing cultural values and mores.

What do we get out of this chapter? It appears likely that, in future, we will have to do "more with less." Although the money may go away, we cannot expect that the demand for service will decrease accordingly. Rural mental health activities will continue to be a functional part of community life. Furthermore, there is a general community expectation that the available services should be broad-based; this obviously conflicts with current and projected budgetary restraints. Therefore, in order to get "more of the less" we must learn to refine our methods of program advocacy. One way is to enlist the aid of allies who can operate outside the governmental system. Another measure is to learn to speak and understand the language of the prevailing bureaucracy when defining program need. It would also seem to be very important to expect more and better community applied research and evaluation from the local mental health centre teams. Hopefully, this Conference will provide the impetus to work in these directions.

RURAL MENTAL HEALTH PROGRAM SURVIVAL

by Stan Remple*

The existence of the Western Interprovincial Conference on Rural Mental Health and the response it has received clearly show that there is a continuing interest in the issues of rural mental health service. I am really pleased to be able to participate, as I wholeheartedly support rural mental health, and I think that this kind of conference is a step in the right direction for useful discussion of rural mental health issues.

The topic of this section is: "Rural Mental Health Program Survival." The use of the word 'survival' suggests that there is some concern about present trends. From my perspective, I think you, as rural mental health professionals, have at least two main concerns. One is the growing anxiety about the difficulty in obtaining funds for the development or enhancement of rural mental health services, and another is the inequity in the allocation of funds to mental health services in the urban setting compared with the rural areas. I would like to try to relate to those concerns.

Although my involvement with rural mental health service is no longer direct, my subsequent roles have probably enriched my perspective from an administrative point of view, and I would like to share that perspective with you. Talking about program survival requires paying attention to at least four major "activity arenas": economic-financial, political, sociocultural, and organizational. By considering them I hope to help you understand better the process whereby rural mental health programs can be better assured of survival.

Economic-Financial Arena

It is obvious to all of us that in a number of ways our economic situation is on a downturn. We look at our salaries in relationship to what we are able to buy, and find that our purchasing power has been drastically reduced. This everyday personal experience of trying to make ends meet is not unlike the kind of experience that faces the government. It is true that, in comparison with other regions, the four western provinces are really not in that bad a shape. However, we are part of a much larger system, and what happens in the larger system is going to affect us sooner or later. We do have an opportunity to anticipate the effects of an economic downturn, and to declare ourselves regarding strategies that will prevent some of the problems.

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* Based on a Keynote Address delivered on September 16, 1981, to the Western Interprovincial Conference on Rural Mental Health. Mr. Remple, then a senior official in the Ministry of Health, Province of British Columbia, is now the Assistant Deputy Minister responsible for Community Care Services in the Ministry of Health.

Governments now find they are facing an increasing problem with the reconciliation of revenues and expenditures. When you add to that a government commitment to have a balanced budget, you compound the problem. Hence we find ourselves necessarily committed to a cost containment strategy. One cannot easily alter this situation in any fundamental way.

How then does cost containment relate to some of the crucial realities we are facing? One answer is that we have to very quickly confront public expectations. Collectively, if we continue to increase our expectations, we really create a dilemma for the government of the day. Wanting to be responsive to the needs of the people, the government tries to meet the expectations; but how do you meet expectations, while at the same time living within your budget? Somehow we are going to have to come up with mechanisms to reconcile these contradictory realities.

There is some evidence that the financial situation has a more negative effect on the mental health of rural people than on that of urban people. Some recent research has suggested that the economic reality is a bigger contributing factor to stress levels in rural communities than in urban centres. If this is true, then we may find that in the rural areas we have more than just a financial problem.

Under cost containment, we can probably expect to see budgets reflect inflationary increases, but for the most part I do not think we can look forward to an early increase of additional real dollars. Although this creates problems, there are a lot of things that we can do in a very creative and innovative way when our backs are against the wall, and funds are tight. I hope that the base line for funding continues in an adequate way; but in the meantime, I happen to be a very strong subscriber to the idea of self-help and mutual aid activities; it seems to me that this is an underemphasized service strategy we now have an "opportunity" to explore.

I have heard that a number of you are doing some very exciting things in this area. I would simply encourage you to continue thinking creatively about promoting self-help and mutual aid efforts. These activities would appear to be very compatible with rural communities where people are very much involved in "natural helping systems." People in small communities talk with one another about a whole range of things; the conversation can simply be about the cabbage in the back yard, and before one knows it, the discussion leads to something else or contributes to a resolution of some other kind of problem.

When we as professionals get referrals from the community for therapeutic intervention, we need to emphasize our early exit from that particular person's situation. We must get the person back into his or her own social network as quickly as possible, and let the community provide the support for continued well-being. I think that is another way of promoting program survival, by using the already existing social supports as much as possible.

Another related issue is how one organizes one's staff. When we have some flexibility, I think we should utilize our most qualified staff in the rural communities, at the intake level. That may not be a very popular thing to say; I remember when I was involved in clinical mental health work, I really liked to be at the receiving end, and intake work was often seen as not particularly important. However, if we are going to maximize our resources we need to bring them to bear at the most critical point; and if that means using our best staff right up front to do an assessment, then we should do so. I think that is an effective and efficient use of staff.

I would like to suggest that one should not complicate the problems that face rural persons. It seems to me that one can do a lot of basic problem resolution through a very simple intervention, such as driving the person to the store, or getting into a conversation with him that may not seem to be directly related to what the problem is, but may turn out to be helpful in the long run. It is the caring attitude I would like to promote.

The other idea that I think is really quite important is that we need to be behaviourally oriented in our consideration of outcomes. I think this is consistent with the rural culture. People are looking at particular problems that they want to have resolved and then to get back into the community. Realistic independence is a positive quality.

Political Arena

Any time you place limits on the amount of monies available, you are by definition creating additional tensions and conflicts. I think that conflict or tension is not always negative, but that it has its good side too. It is our handling of it that becomes critical.

I do not have to tell you that it is very difficult to rally the public around the mental health banner. There is not that organized constituency out there among consumers that is so often found in other health areas. This is extremely important because our political system works on the basis of the supports and pressures that constituents bring to bear on it. Out of that process there flows a choice as to the possible allocation of available money.

I think we sometimes tend to burn ourselves out unnecessarily, trying to advocate on behalf of mental health. Certainly we have to advocate for mental health; but there is a danger of becoming overzealous, of going beyond the realistic limits that are there. I think we have to push hard, but also accept the fact that the "decision" sometimes contradicts our preferences.

Our political system has a lot of imperfections, and we have to continue to persevere in our efforts to improve it. When we are looking at interest groups, it is not hard to see that those who actually stand up on behalf of the clients we serve are the professionals themselves, and I applaud them for that. I hope they will keep it up. I would, however, like to point out that, given the number of options that are available for advocating within the system, the professionals, who are public servants as well, have to be careful to be both responsible and optimally united. From my position in Treasury Board and now with Health, I notice that a lot of professionals waste valuable energy on process issues. Professionals are not united in terms of outcome, and it seems to me that if they would remedy that, they would constitute a much stronger force.

I would also like to make another observation concerning requests for resources related to primary or secondary prevention. It seems to me that too often, unfortunately, we find ourselves in a "crusade situation," where we have convinced ourselves of the need for preventive health services, but have not really been able to sell the idea to other people. We must justify our position on the basis of more than simply saying that it is a good idea. When I look at budget requests submitted to Treasury Board, for example, I find it quite amazing the kind of information that is sometimes used to support the request for funds. Generally, in our western society, we are faced with the difficult problem of justifying the allocation of funds for preventive services. That is a major challenge. That problably also suggests that we need to reduce a little our pressure for funds, until we are more solidly grounded in fact. When we ask for funds, without a sufficient factual base to support the requests, we very quickly lose credibility with politicians. They become impatient and alienated from the people who need their help.

Another problem facing rural communities is under-representation relative to urban communities; they are therefore at a disadvantage in accessing funds. To alleviate this, we will have to come up with strong arguments about the difference and inequities, and to identify some of the social costs that accrue to rural communities which urban communities do not carry. This type of information would be very effective as a means of supporting budget submissions.

Since rural areas are politically under-represented, groups like the Canadian Mental Health Association are going to have to play an increasingly prominent role because of their external position, as it is difficult for people within the system to advocate strongly. From my point of view, I fully support a much greater involvement of the Canadian Mental Health Association in this process.

Having said this, I think there is one final reality which is very important to recognize from a political point of view. Generally, politicians need to have funds left available for unanticipated circumstances. These political contingency pools are growing smaller and smaller, which means that a Minister will guard against the use of such funds. This is the sort of thing that professionals should know when they are lobbying for funds from the Ministry.

Socio-Cultural Arena

I have already indicated that mental health is not a flag around which the public rallies. Indeed, there is a stigma attached to mental health in general. I would say that if one looks at the most rural areas of the world, that stigma is quite strong and relatively well defined. It is my perception, and I am open to challenge on this one, that rural folks, and I am not talking about the transplanted urban people, are more likely to have the stigma than are people from urban areas.

Rural people appear to have unique ways of coping with many of their mental health problems. On the one hand, there appears to be a much greater degree of readiness among rural people to accept abnormal behaviour; but on the other hand, I think they have difficulty dealing with the behaviour in a constructive way because the social patterns they find themselves in are the ones that contribute to the problems in the first place. In terms of seeking help, it seems to me that until a problem gets out of hand, we often see rural and urban people alike going through their confidants in the community. When it comes to seeking help with a serious problem, there is a tendency to resort to medical services such as the psychiatrist and the hospital instead of the community services, although this is gradually changing. We need to respect a person's inclination to seek help from a particular place. We often find ourselves getting into professional rivalries in this kind of situation, when it really is not necessary or productive.

Recently some priority statements were made in B.C. which placed services to the chronic population first, services to acute population second and adjustment problems third. How far can we really go in terms of primary and secondary prevention? I am really not sure. If one looks at what is happening in the United States, where they are much more into cost containment than we are, the primary and secondary prevention level programs are becoming casualties. I am not saying that it is going to happen here, but I do not think we should be too surprised if that kind of tendency develops.

Organizational Arena

I would like to address some organizational, inter-organizational and management concerns. Many people tend to rely on what they call "improved management practice" to resolve problems, and to address financing problems. One has to be careful not to say that all solutions are a function of improved management practice. However, improved management practice can be a useful vehicle through which we can develop good solutions. With that in mind, I would like to address three areas with you: general management practice, program policy management, and service delivery management. The more you can respond to these three areas, the more successful you will be your quest for shrinking resources.

(a) Program Policy Management

We need to re-examine what we are really about by asking what the parameters of what we do are. Certainly there is no agreement about this on the different levels within the system, and as a result we are going to have considerable difficulty down the road.

I think the question of who makes the decisions is an important one; what I am really talking about here is the politician in relation to the bureaucracy. It is very easy for a bureaucracy to become a maintenance-type organization that is self-serving and self-preserving. I think that senior people in a Ministry must become advocates for change; but to be successful at advocating change, they have to hear what the concerns are at the field level, how they translate into policy options, what the pros and cons are, and then try to anticipate what the responses are going to be all the way up the management hierarchy. The senior bureaucrats need to hear what you have to say, and it needs to be translated in such a way that your message is not lost. When it comes to policy initiatives, decisions must not be made at the highest level within the buraucracy without input from line staff.

The senior people of the Ministry have to decipher the information received from the field, develop policy options, look at them in terms of pros and cons, and perhaps put forward a preferred option; but the choice is ultimately made by the Minister and his colleagues. In that sense the Minister has become much more of a chief executive than he has been in the past. Indeed, we are finding ourselves in a situation where the Minister has less financial flexibility, and in which it is important for him to have options. To my way of looking at it, this is a logical way of making decisions, given the current economic constraints alone. I recognize the imperfections and there are lots of them, but I do not know of a better way of advancing the public interest.

When we get into new activities, I think we need to become much more concerned with policy analysis, policy research and pilot projects, and to develop a much greater degree of mutual information exchange between the field and headquarters staff. It seems to me that we sometimes lose monies that we might otherwise receive because we ask for too much, given the current economic circumstances. If we would "think small" to begin with, and develop things from there, we would be more effective and would gain more credibility with the senior staff.

Many of you are concerned about how the hospitals are able to access resources easily while funds for mental health services are hard to come by. From my vantage point, there are at least two things that one can look at to explain the funding inequities between Hospital Programs and Mental Health Services. First, when I am involved in the budgeting process and a budget request comes in from Mental Health, and another one comes in from a Hospital, I compare the two and see how each program field has interfaced the budget development process with their package request. But I also look at the budgets from a frame of reference which says that there is a need for a distinct mental health capability within the province, and that it itself becomes a viable focal point during consideration of the budget. However, we must recognize that mental health does not have the kind of influences comparable to those of the hospitals, and that may be something that we have to live with and deal with slowly over a lengthy period of time.

We need to establish a much better linkage with the public health or preventive health system -- to do some more conceptualizing about what kinds of disease patterns we are dealing with, and to identify what can be done from a preventive point of view. Now that is happening at the informal level, but I think we have to formalize the process a lot more. Since prevention is a rising priority within the various jurisdictions, a clear and well defined linkage with Preventive Health would have a positive effect for Mental Health at budget time.

(b) Management Practice

People often ask: "Why emphasize planning so much? After all, planning is all so politically expedient." The answer is that there must be consideration given to the political aspect, but that the political system is able to make much better choices if we provide it with appropriate planning inputs. Although the proposed plan may not be accepted, at least it will influence the decision that is subsequently made.

We have to do a lot more work at identifying and defining our needs. When requests for funds are made, we find that the definition of needs varies a great deal. Some people identify needs as wants, but the two are different. When it comes to objectives, one can look at what one wants to achieve, and what Treasury Board wants to achieve in relation to what you need to maintain your basic program. Treasury Board is looking increasingly at what you need to do on the basis of program service units, which may lead us into a greater concern with efficiency. I probably have as much difficulty with this as you do, but I do recognize that as an inevitable reality of cost containment. If you want to "make the most with your buck," you also somehow end up centralizing control in the interest of becoming more efficient. Therefore, the concern with units of service becomes an increasingly important topic in your preparation of budgets.

Many of you are aware of the fact that we are getting into zero based budgeting in British Columbia, and perhaps you have anticipated that it will allow for more flexibility and freedom at the field level. I do not know how much flexibility you can expect, but I do know that taking it seriously is certainly not going to harm you, while not taking it seriously probably would. I think zero based budgeting reflects our concern for a certain type of budgeting which is not simply adding ten percent to last year's funding level. It calls for rationalizing what we want to do with the money that we are expecting to get. By not doing that kind of conceptual work beforehand, you leave the door open for somebody else to make arbitrary decisions that are only going to create more problems for you.

Something we are going to be looking at much more is budget integration. In fact, next week when I get back to my office, I will be going through the zero based budgeting ranking process,and we will be looking at certain criteria, one of which is the extent to which Mental Health Services are comprehensively addressed. We are not going to look at that without considering what is happening in the Hospital area.

Another concern that I know some of you have relates to resource acquisition in relation to staffing flexibility. Like other provinces, we have been looking at an expanded definition of what a staff establishment is. Instead of simply considering numbers of options, we are now looking at flexible use of a given number of manhours. I think there are present rigidities associated with the establishment concept, but there are also options that have the potential to serve the needs. Implementation of sessional and "full time equivalent" arrangements have special appeal for rural services. There is a risk involved whenever actual positions are converted to FTE or sessional funding, as such funding arrangements are much more accessible to budget cutters. However, such arrangements can be rationalized in the interest of more effective and efficient service, and I would certainly support that.

I would urge you, from a program point of view, to begin thinking seriously about evaluation. It may not help you get more funds, but it may well help you keep what you have now. Senior management is going to become increasingly interested in evaluation,given the money crunch that is currently developing. The concept of consumer satisfaction is an important component of our evaluation efforts, and we must begin to think in terms of how our clients are reacting to the service we provide. This also means that we must give consumers the understanding needed to arrive at their own conclusions.

(c) Service Delivery Management

From an organizational point of view, I think we are going to see a much greater emphasis on integrating and centralizing operations, rather than having many streams of reporting lines from headquarters to the field. Direct line reporting relationships, and therefore more integration, will result in the more efficient use of our resources. Decentralization will be more a function of carefully delegated operating responsibilities.

A development that is appearing in all the provinces is the notion of "regionalization." There are many arguments supporting regionalization, and in today's climate it has a lot of support from a cost containment point of view. On one hand, smaller units enable you to gain a much better grasp of what the issues are, and to carry out "fine tuning." On the other hand, there is increased responsiveness to the community, which is very important. Regionalization is really a way of responsible cost containment.

Conclusion

I want to say in conclusion that we tend to make a lot of assumptions about our senior managers. We need managers who are prepared to listen to what we have to say. We need an open line of communication to the top, to feel assured that we have been heard, and that the ideas we would like to see pursued are seriously considered. They may be eliminated in the final analysis, but I believe that both you and I could live with that kind of decision.

Looking back on my rural experience, I realize now that I often found myself tempted to embellish the budget in the hope that I would get what I really wanted. That may work sometimes; however, at some point I think that attitude catches up with you and creates some credibility difficulties that you did not count on. I have found that the best way to deal with this is to be completely open and honest. You may still lose something in your budget, but you will gain in credibility, which is more important in the long run.

One very important organization development initiative I would like to promote is an annual problem or issue survey conducted throughout the whole system, gathering information on things like staffing ratios, job satisfaction, concerns or questions of any kind. Even with the best intentions, there is a danger that senior executives can often alienate themselves from what is happening in the field. I would like some mechanisms introduced to reduce that danger. However, it is also important that field staff understand the constraints faced by senior headquarters staff.

I have touched on a lot of issues fairly quickly, some of them not very popular issues. I must emphasize that I certainly do not pretend to have the answers. I have simply stated one person's opinions. Let me conclude by urging you to consider seriously and critically the action implications of the points I have made. As I see it, serious consideration of these points is needed to retain the resources you now have. You may even be able to translate some of them into acquisition of additional resources. I want rural mental health services to survive and thrive.

THE RELEVANCE OF THE FIVE ESSENTIAL MENTAL HEALTH SERVICES TO RURAL MENTAL HEALTH*

By Alan Rendle, Ph.D.**
Prince Rupert Mental Health Centre
Prince Rupert, British Columbia

According to one of the basic tenets of community mental health, the following five "essential mental health services" are required for a comprehensive mental health program:

1) Inpatient care
2) Outpatient treatment
3) 24-hr emergency service
4) Partial hospitalization
5) Consultation/education.

These five services are to be provided to catchment areas with populations of 75,000 through 200,000.

To date, there appears to have been little attempt to investigate what services should be offered and how these should be structured in rural areas with smaller populations. This paper addresses the need for more research in the area by investigating the relevance of the five essential mental health services to rural communities of less than 75,000 people. The investigation focused on Prince Rupert (population 18,500), located on the north-west coast of British Columbia, and, to a lesser extent, on Terrace (population approximately 18,000), located approximately 100 miles inland from Prince Rupert.

Inpatient Care

Inpatient services are available to the residents of Prince Rupert at the psychiatric unit of the Prince Rupert Regional Hospital. Although there is no separate psychiatric ward, nine beds are allocated for psychiatric patients. The primary service is from regular hospital staff, although a part-time nurse clinician is available for psychiatric patients upon request of the admitting doctor.

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* Considerable appreciation is due to Dale Newell, Administrator of Prince Rupert Mental Health Centre, for his large input into this study, and to Tom Blake, a summer student who was hired to gather the data.

** Now at Maple Ridge Mental Health Centre.

Over a 15-month period, the nurse clinician saw 167 patients, (an average of 11.1 per month). Ninety-eight (58.6%) of these patients were suffering from problems of anxiety and/or depression. Only seventeen (10.1%) of the total number of patients were identified as schizophrenic. The remaining fifty-two (31.3%) comprised a mixture of family problems, character disorders, alcohol and drug problems, and geriatric cases.

It was concluded from this preliminary data that inpatient services should, indeed, be regarded as essential mental health services in both rural and urban areas. However, they should be designed in rural areas to deal primarily with acute disturbances such as anxiety and depression. The obtained data suggested that it would not be practical or feasible to develop a fully functional psychiatric ward of the type needed to treat chronic patients, as this type of service requires extensive inpatient programming, occupational therapists, psychologists, social workers, psychiatrists, and so on.

In Prince Rupert, most of the chronic patients are sent to major psychiatric facilities on the lower British Columbia mainland or to the psychiatric unit of the Terrace hospital. The psychiatric unit in Terrace possesses fairly extensive inpatient facilities and programs, and is thus capable of treating most chronic patients. It has also been operating for a number of years as an unofficial regional psychiatric centre for the surrounding areas. For example, during its first year of operation, 50% of the two hundred patients receiving care came from the surrounding areas.

Using the psychiatric unit at Terrace as a model, it was determined that there were far more advantages than disadvantages to establishing regional psychiatric centres in rural areas. The advantages might be summarized as follows:

1. This system is more cost effective.

2. It is easier for family members to visit as they would not have to travel as far.

3. In many cases, the regional psychiatric centre would be close enough to the surrounding rural communities that a partial hospitalization program could be developed. This would enable patients to go home on weekends before release, which, in turn, assists the transition into the community.

4. Follow-up treatment is easier to arrange.

5. A well staffed facility could offer specialized - consultation/education services to outlying areas.

6. Attracting and retaining specialized staff would probably be much easier for a functional psychiatric regional centre than it currently is in rural areas, where mental health services are typically poorly developed and supported.

There are, however, some disadvantages to this approach as well. For example, there might be civic rivalries regarding the actual placement of the regional psychiatric centre. There might also be some referral problems, as some general practitioners would probably continue to refer their patients to the major psychiatric facilities in the urban areas of British Columbia. (There is a rather common stereotype that better or more sophisticated service is to be found in urban areas.) For some patients, the differentiation between acute and chronic problems is not always clear; consequently, there could be some conflict about whether the individual should be treated in the regional psychiatric centre or the outlying centres.

It was concluded from this data that regional psychiatric centres should be developed in rural areas for the treatment of chronic mental health patients rather than continuing to send them long distances to major urban-based psychiatric facilities. The target population for such a regional psychiatric centre should be at least 75,000 as this is regarded as the minimum size necessary for the development and utilization of fully functional inpatient facilities. The mandate of the regional psychiatric centre would also include offering specialized consultation/education services to the outlying psychiatric units, which would be designed primarily to treat acutely disturbed patients.

Outpatient Treatment

In the community of Prince Rupert, outpatient services are available only at the Prince Rupert Mental Health Centre. At the time of this study, the staff consisted of a psychiatric social worker/administrator, a psychologist, a mental health nurse, and a social worker temporarily stationed at the centre until facilities could be found to establish a permanent satellite office on the Queen Charlotte Islands.

During the review period (January through March 1979), it was found that the outpatient program involved a total of 349.5 hours of therapy and diagnostic services (an average of 116.5 hours per month). A review of the Centre's service logs revealed that outpatient services accounted for approximately 25% of total working hours.

One simplified way to assess the outpatient program of any clinic is to look at the average treatment time per patient. A sample of 116 ex-clients was taken, and it was found that they received 600 scheduled appointments. In other words, each client received, on the average, 5.1 therapy sessions. However, a number of clients in the sample were couples receiving marital or family counselling. This means that the average treatment time per case was more likely 6 - 8 sessions. These figures indicated that most of the clients were acute rather than long-term chronic cases. This further suggested that outpatient services in rural areas should be designed primarily for the acute rather than the chronic patient. It was concluded from this preliminary data that outpatient services do, indeed, form an essential mental health service for both urban and rural areas.

An unexpected finding was the large amount of time (657 hours) spent in administration. A review of the service logs revealed that administration took an average of about 35% of the Centre's total time.

Further analysis revealed that the mental health nurse and social worker for the Queen Charlotte Islands had recently been hired and that neither one had worked in community mental health centres before. As a result, a large part of their time was spent in "administration," i.e. in learning their new roles. The analysis also discovered examples of administrative problems associated with the Centre's remoteness from Provincial "headquarters." It was concluded that administration may be more of a problem and take more time in rural than in urban areas because of staffing and distance problems. The administrative patterns of rural mental health centres require further study.

Consultation/Education

The Prince Rupert Mental Health Centre provides consultation and education services that deal directly with mental health issues. During the review period, the Centre's consultation/education activities totaled 469.5 hours. These services were found to average around 40% of the Centre's total time as compared with the 25% for outpatient services and 35% for administrative time.

The high percentage of time devoted to consultation/education indicated that this function should certainly be considered an essential mental health service in rural areas, and should probably have a higher priority in rural than in urban areas. This is because rural areas do not have the same number or variety of specialized mental health workers. Therefore, other community agencies will more frequently turn to the few available mental health workers for consultation, particularly client consultation. Furthermore, rural areas don't have the same variety or number of mental health programs; consequently, a greater amount of time is usually spent in developing new programs and improving existing programs. The same is true with mental health education. Rural area have far fewer educational resources, particularly for dealing with mental health issues. The Prince Rupert Mental Health Centre's catchment area, like those for most rural mental health centres, covers a vast territory; many regions can only be serviced by travelling clinics. Since during the period surveyed it was only possible to conduct travelling clinics every three to five weeks, it was exceedingly difficult to offer regular outpatient therapy services. Thus, the focus of the travelling clinics was on consultation and education services.

24-Hour Emergency Services

A very popular method of providing 24-hour emergency mental health services today is by means of a 24-hour crisis line. Prince Rupert had a crisis line that had just disbanded prior to the initiation of this study. When the crisis line was initially organized, there was overwhelming support both from the different community agencies and from the community itself. The crisis line was located at the local hospital, which provided room and a phone line. The volunteers were trained by the mental health centre staff. However, after 6 months of operation, only six crisis calls were received; as a result, the volunteers became very discouraged and the service was discontinued.

Terrace also had a crisis line which had been in operation for a number of years. It was found that they had gone through exactly the same transition and within the first 6 or 8 months were ready to close because of the lack of callers. However, they totally restructured their line so as to offer a broader variety of community services. In fact, at the time of this study, none of the volunteers had training in crisis intervention; they simply acted as a referral service for any crisis callers.

A very limited survey of other rural communities revealed that some of them also had crisis lines which had closed because of a lack of callers. One rural community that still had a crisis line in operation had hired a telephone answering service which transferred the crisis calls to the volunteer's home. This worked fairly well as it stopped the volunteers from becoming bored or discouraged when there were no calls.

It was concluded from this preliminary data that 24-hour emergency services in the form of crisis lines are not as relevant or essential in rural as compared with urban communities. In order for such a line to survive, it has to offer a number of other community services, or possibly have an answering service to transfer the calls to the volunteer's home.

Partial Hospitalization

The term "partial hospitalization" is used today to refer to a broad variety of services, most of which are also called by other names, e.g. day treatment or day hospital programs, sheltered workshops, halfway houses, group homes, hostels, boarding homes, and so on. Most partial hospitalization programs are developed for the chronic rather than the acute patient.

At the time of this study, Prince Rupert had no partial hospitalization programs. Consequently, an effort was made to assess the chronic patient population in the community and to determine what percentage would benefit from some type of partial hospitalization program. A review of this Centre's files revealed 28 patients diagnosed as schizophrenic or manic depressive who also were on medication and could be classified as chronic patients. This group obviously did not include all the chronic patients in the community, as it is usually estimated that there are between four to ten chronic patients per thousand population. It would be expected, then, that approximately 74 chronic patients would be in Prince Rupert.

It is also generally recognized that around 7% of chronic patients need day care; some 20% require residential care; and, approximately 80 to 85% need rehabilitative services. Seven percent of the 28 clients registered at the Prince Rupert Mental Health Centre equals 1.96 clients. Even if one assumes that there were 74 chronics in the community, this would still work out to only 5.1 clients requiring day care, which indicates that it would not be very practical to set up the day care program. If, on the other hand, 20% (5.6 clients) of the 28 clients at the Mental Health Centre need residential care, this would indicate the need for a small boarding home for about six clients. In order for a boarding home to operate properly, it should also offer some type of simple programming or rehabilitative services. A boarding home plus rehabilitative services is currently classified as a transitional service.

Thus, it was concluded from this preliminary data that partial hospitalization, in the form of boarding homes, should be classified as an essential mental health service in rural areas. It was additionally concluded that, in rural areas, transitional services such as a boarding home providing rehabilitative services should be regarded as the fifth essential mental health service (replacing 24-hour emergency services).

Conclusion

The purpose of this study was to investigate the relevance of the five essential mental health services in rural areas, both in terms of the type of structure needed and in terms of the demand for these services. This was an exploratory study only and none of the conclusions reached or suggestions given are meant to be definitive. These preliminary findings do, however, point out the need for more and continued research in the area of essential mental health services for rural areas.

PROGRAM SURVIVAL - STABILITY ISSUES

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Trail Mental Health Centre
Trail, British Columbia

This paper deals with the question of maintaining an image of program permanence and trustworthiness in a rural community despite staff turnover, policy changes, conflicting policy messages and other factors affecting program stability. The issues are dealt with under five major headings:

1. Professional Training and Commitment.
2. Developing The Interagency Network.
3. Direct Service Accessibility to the Public.
4. Community Groups, Personalities and Life Style.
5. Political, Policy and Funding Factors.

The manner in which these issues are resolved has a significant influence on maintenance of programs, extent of community support, staff "burnout," expansion of needed services and, ultimately, the wellbeing of a relatively large percentage of the area's population.

Overview

The Trail Mental Health Centre was opened in May, 1964 as the third Mental Health Centre in British Columbia outside the two metropolitan areas. It initially served a catchment area of some 165,000 people, encompassing a region of some 15,000 square miles of mountainous country. Travelling clinic services were provided to Cranbrook (150 miles east), Nelson (50 miles north), and Greenwood (100 miles west). The staff included the author (Social Worker, M.S.W.) and a Psychiatrist (G.R. Mansfield). The establishment of Centres in Cranbrook (1969) and Nelson (1970) reduced the catchment area of the Trail Centre to 45,000 population and some 4,000 square miles encompassing the larger cities of Trail, Castlegar and Grand Forks. Mental Health sub-offices were established in Grand Forks (1974) and Castlegar (1977). Staff now consists of the equivalent of six full time professionals and 2.5 clerical staff.

The cultural make-up of the population of the region is of some significance. Trail has a large Italian-Canadian population while Grand Forks and Castlegar have the largest number of Russian Dukhobor residents of any community in British Columbia. Greenwood was an internment centre for Japanese-Canadians during World War II and their influence is well established in that community. The Slocan Valley north of Castlegar attracted a large number of "counter-culture" people during the turbulent 1960's.

Industrial and economic stability is represented by Cominco (4,000 employees) in Trail, Cancel in Castlegar, and several sawmills in the Grand Forks-Greenwood area. The population and economic mix provides a considerable challenge in ensuring program and direct service capacity.

Stability Issues

The ability to establish and maintain program stability is largely dependent on five major factors:

a) Professional Training and Commitment

Each member of the rural mental health team should have fully recognized professional qualifications. This is critical to program stability for the following reasons:

i) The professional must demonstrate that he/she can do the job before the community role of consultant, educator, adviser, and/or resource developer is accepted.

ii) There is minimal local access to consultation from educators and authorities in the mental health field.

iii) While the psychiatrist tends to be labelled as "the shrink," other rural team members may initially carry more restrictive stereotypes. For example, the social worker is often seen as the "welfare worker"; the psychologist as "the tester"; and the nurse as the "physical care giver." Therefore, each rural team member must be able to demonstrate competence lin therapy and other mental health program areas.

iv) In rural areas the concept of the "independently competent" practitioner is extremely important.

v) Communities have high expectations of mental health "experts"; confidence, commitment and credibility must therefore be based on a solid background of professional training.

The successful resolution of these issues leads to program stability as reflected in frequent agency referrals; increased self-referrals; development of necessary resources; demand for consultation, education and advisory services; staffing; and a positive community image.

b) Interagency Network

No program can be effective without broad-based acceptance within the community agency and professional matrix. Our Centre has achieved this by:

i) giving direct, informal and respectful access to all agencies and professionals while adhering to the principle of non-violation of the clients' time.

ii) use of the "circular" letter technique to keep agencies and professionals of up-to-date on the Centre's program, staff, and policy mandate.

iii) initiation of "community agency workshops" to foster interagency communication.

iv) provision of orientation to other agency staffs.

v) provision of workshops, training programs and student placements.

vi) serving on interagency and professional advisory committees.

vii) encouraging feedback regarding programs and services.

viii) accepting the roles of other care-givers without "ego tripping" on the so-called "expert" label, while mutually and realistically establishing limits.

ix) communicating a position of neutrality and independence that recognizes the mental health aspects of all community services.

c) **Direct Service Accessibility to the Public**

Long-term stability of program is based on the ability to provide the kind of service demanded by the community. This has been achieved by:

i) recognition that clients want help to solve their own problems.

ii) respect for confidentiality rights of the client.

iii) clear and non-jargon explanations to clients regarding services that can be expected.

iv) working "with" rather than "on" the client.

v) maintaining at least minimal capability for "crisis" situations.

vi) frankness in setting limits of service to clients.

vii) eliciting client feedback through client and community surveys.

Adherence to these principles has enabled our Centre to gain client support in developing more effective services.

d) Community Groups, Personalities and Life Style

The Centre can add to its "presence" in the community if staff are identified as concerned citizens in the affairs of the area. This can be achieved by:

i) staff members involving themselves as individuals in non-partisan, broadly based community activities and projects.

ii) establishing personal and professional credibility in public and personal activities.

iii) differentiating between personal life styles and professional responsibilities.

iv) maintaining accessibility to community groups (e.g. some 300 talks, workshops, etc., over 15 years by our Centre).

v) developing an intimate and respectful knowledge of all areas of community life.

vi) truly accepting your right to be an individual but recognizing that your lifestyle must respect community sensibilities.

vii) a firm decision not to allow clients, community groups and other professional activities to intrude excessively on the "free time" of personal life.

viii) letting your personality show to modify the "untouchable expert" image.

ix) appreciating the role of humour.

e) Political, Policy and Funding Issues

These are much more significant for expansion of programs than for stability.

1) Political

Twenty years of personal experience in B.C. rural mental health has reinforced our opinion that the minimal political support for community mental health programs (presently .6% of Provincial Budget) is based on a common attitude that emotional problems are individually caused ("you made your bed so lie on it"). This assumption or stereotype prevents people from talking openly about their involvement as clients. Moreover, the difficulty of quantifying treatment outcomes promotes the belief that little can be done to change emotional disturbances. These two factors hinder the development of broad political support. While political and professional concerns often conflict, however, educating significant community groups about mental health has produced a gradual but encouraging increase in support for program development.

2) Policy

It is clear that the frequent "reorganizations" by the B.C. Ministry of Health at the senior administrative levels have not generated the necessary impetus to build more effective community mental health programs. However, the ongoing confusion and frequent contradictory changes at the senior level have, in many ways, resulted in greater local autonomy. Consequently, within limits, the Centre is relatively free to be responsive to the clearly established mental health needs of the community. The present Ministry mandate, in fact, coincides well with the program and service priorities of the Trail Centre. It is vitally important that the focus be primarily on community need and professional responsibility, commitment and ethics rather than on personal political orientations.

3) Funding

To state the obvious, only people (hopefully, qualified professionals) can treat people. Therefore, the main funding issue continues to be the ability to employ sufficient professional and support staff to meet the mental health needs of the community. Stability requires making decisions which maximize the use of available staff resources in combination with a stable volunteer program. The latter can best be achieved, in our experience, through a paid Volunteer Co-ordinator supported by a strong C.M.H.A. Board and membership. The partnership of professional and volunteer can be most effective in service to clients. Community awareness through Mental Health Centre accessibility is the most fruitful course toward achieving an adequate level of funding. Finally, it is essential that we advocate strongly the development and maintenance of in-service continuing education funds which, in our opinion, are vital for the recruiting and keeping of staff and for avoiding "burnout" and professional isolation.

Finally, it is our belief that a strong staff commitment to providing a quality service can tip the balance in favour of progress in spite of political, policy and funding problems.

STAFFING ISSUES: ATTRACTING AND KEEPING RURAL MENTAL HEALTH STAFF

A.H. Thompson and D.M. Barr
Alberta Mental Health Services

This workshop comprised two distinct sessions. The first was a presentation of some of the major issues involved in recruiting and retaining rural staff, based upon the observations and experiences of the presenters and on data collected by Didow (1980) on rural mental health services in Alberta. The second session involved all of the workshop participants in a discussion of the issues, and in the production of a set of specific recommendations.

I. ISSUES

A. Problem

Does the recruitment and retention of rural staff present a problem? The clearest evidence is provided by Didow's survey, which found a vacancy rate of 24% for rural positions, compared to 10% for urban. Our observations are consistent with this finding. In one rural centre, four consecutive job competitions produced a total of five interviews. In another, the only two positions were vacant for 1½ years.

B. Principles

Because of recruitment and turnover problems, the temptation is to relax standards. We suggest the following principles:

1. Staffing continuity is important in rural areas.
2. Rural staff should be better qualified than urban workers.
3. Rural staff require more back-up and staff development than urban workers.
4. There should be no diminution of clinical standards because of rural location.

C. Recruitment/Retention Problems (these are discussed together because most issues are common to both).

1. The recruiting process: Recruiting takes a minimum of three months if all goes well. ("All" usually does not go well.) This leaves positions vacant for extended periods of time, and means that we often "miss" people who wish to live in a rural area,

but cannot wait for the bureaucratic process to run its course. (Didow reported that 27% of rural employees accepted their position because of the lifestyle it offered.)

2. Salary: Classification levels ordinarily do not allow salaries adequate for a qualified "generic" worker.

3. City bias: Most therapists would prefer to live and work in the larger centres.

4. Professional isolation: In the Didow report, 50% of respondents rated this as the greatest disadvantage of rural mental health work.

5. Personal isolation: For those raised in urban areas, the move to a rural setting inevitably results in a conflict between imposed lifestyle and needs. Didow reported that only 22% of rural workers were previously rural residents.

6. Advertising: Didow's study showed that 50% of rural workers heard about their present position via word of mouth, and another 33% through newspaper ads. None of the workers received news of the vacancy in professional journals or through Canada Manpower.

7. Inadequate provision for staff development: Thirty percent of Didow's respondents reported this as the greatest disadvantage of rural work. Although 40% felt inadequately informed, only 2% of rural worker time was spent on staff development.

8. Burnout: Although it was felt that this is an over-used concept, the evidence is that the workers surveyed in the Didow report averaged 50% more registrations than their urban counterparts. This, coupled with a high community profile, lack of professional support, and other factors noted above, represents an issue that must be addressed in staff retention.

9. Career development: The reality is that in a rural posting, there is rarely a position available to be promoted to. Reclassification is not usually possible.

D. Contradictions

The problems noted above might suggest that all rural workers must, by definition, be difficult to recruit, impossible to retain, and unhappy at their work. It is important to note that most rural workers are in fact, happy in their jobs. Didow found that 54% of respondents classified themselves as "very satisfied" in their work, and a further 33% were "somewhat satisfied". Forty-five percent indicated that they planned to remain in their positions for at least three years. The high registration rate noted under "burnout," above, might be reinterpreted as evidence of a satisfying and productive work situation, rather than as a problem. Recruitment and retention are problematic, but not for every location or for every worker.

II. RECOMMENDATIONS

The second portion of the workshop was designed to result in a set of specific recommendations based upon group discussion of the issues involved. Participants were asked to produce recommendations of the type that could be examined and acted on by senior decision makers (i.e. those who control policy and funding). Those recommendations that were retained were voted on and ranked in order of importance.

Note that the recommendations are few, and can hardly be classified as frivolous or self-serving (salary was only ranked as #4).

A. Participants

D.M. Barr, Alberta
Rosa Fun, B.C.
J. Glasgow, Manitoba
Kathy Leckie, Manitoba
Dean Lutz, Manitoba
W.F. Nelson, Alberta
E. Sigurdson, B.C.
A.H. Thompson, Alberta

B. Ranked Recommendations

1. On-site interviews, including meeting local staff and area tour.

2. Encouragement of a true interdisciplinary team approach (sharing skills, nurturing, support).

3. Reduce vacancy time after a resignation:

   (a) Maintain eligibility list of candidates.
   (b) Regionalize personnel departments.
   (c) Begin recruiting when resignation received.

4. Higher salaries to allow hiring of competent staff:

   This to respond to different market conditions in rural areas and because rural areas require better qualified staff than urban areas.

5. Two days per month to be assigned to staff development with adequate financial support.

6. Legitimize flex-time and time off in lieu of overtime to compensate for extra hours worked.

7. Inclusion of spouse in initial recruiting trip (i.e. expenses paid).

REFERENCE

Didow, D. Report on rural mental health services delivery in Alberta. Alberta Mental Health Services, Red Deer, 1980.

PUBLICITY: HOW TO USE THE MEDIA

Ron Brown, M.S.W.
Executive Direction, B.C. Division
Canadian Mental Health Association

Questions you should ask before beginning

1. Is publicity necessary?
2. Can we handle the business we create if we advertise?
3. Is it ethical not to advertise? Don't taxpayers have a right to know about what they are buying?
4. Do you know your target population?
5. How can you best reach your target population?

Remember - in most cases people don't pay attention to this type of "program/service" information until it affects them directly.

Publicity Do's and Don'ts

DO's

1. Do prepare the press release with enough room for the editor to make his changes.
2. Do remember that media people are very busy, and are receiving similar demands from all corners of the community.
3. Do provide as much written background material as possible; often news clips turn into full feature articles.
4. Do name on the release an available contact person who is well-informed and readily available.
5. Do make an initial contact with the media even though you may not have a newsworthy article -- simply to let them know that you're around and that you intend to use them whenever possible.
6. Do send the same information to all media (radio, T.V., Newspapers). The media game is a highly competitive business, and confusing or different information would most certainly alienate some good contacts.

7. Do send your release to your persnal contact. If you have no contacts, send it to the city editor (newspaper) or the assignment editor (T.V.).

8. Do know the deadlines that the different media work on, e.g. daily, weekly, and monthly publications.

   Generally mornings are bad for newspaper people and afternoons (2 till 5) are bad contact times for radio and T.V.

9. Do remember to publicize in other media such as church bulletins, service club newsletters, etc. This type of contact should be personal and the information should also be personalized.

10. Do publicize the program/service with other community workers, i.e. doctors, lawyers, Indian chiefs, police, the clergy.

11. Do ensure that the telephone listings for your service are easy to find; i.e. you may be listed under the formal name of the organization such as "Canadian Mental Health Association," but a generic listing such as "Mental Health" is also a must. People in distress require easy access to services.

DON'TS

1. Don't go to the media unprepared and assume that they will do the work for you.

2. Don't go on bended knee: they aren't doing you a favour, it's their livelihood to handle all newsworthy information.

3. Don't miss appointments -- media people are always on the move. For example, if you schedule a photograph at 4:00 p.m., be there. The photographer will likely have another assignment somewhere else at 4:15.

4. Don't mess around with media people -- on the whole they are very dedicated people who want information now and they want it short and sweet and honest. You will not succeed in manipulating the press!!!

Issues of Style

1. Always prepare a press release or story in the inverted pyramid style; i.e. the first one or two paragraphs should have all of the key information: who? what? when? why? where?

   You must do this because people often do not read an entire article. As well, if the newspaper cuts the article it is always cut from the bottom.

2. Headlines -- newspapers have one person (the copy editor) who decides on all headlines. Help him -- give him a focus. Think of the people you wish to reach and decide what will catch their attention.

3. 200 to 300 words is the maximum length for a news article (other than features).

4. Always type the release -- double spaced.

5. Leave wide margins so that the reporter or editor can make his own notations.

6. Newspapers often have 2 typesetters working at the same time, each doing part of an article, so always identify each page of your release on the top, and indicate on the bottom if there's more to follow.

7. Personal Presentation -- Public Appearances

   (a) You are the visual presentation of the service; thus, dress and decorum are important.

   (b) Make the contact ahead of time and brief the interviewer well.

   (c) Try to establish a conversation with the interviewer rather than attempting to make a presentation -- he will draw the information out of you!!

Miscellaneous Tips

1. In company towns be certain you contact the major employers and the unions.

2. Local colleges often run short programs on many "mental health" topics and they will often collaborate with you in this regard.

3. In many cases public announcements are free provided you are not paying for advertising in another medium.

4. Often large companies (some small ones too!) will sponsor air time for your publicity needs.

5. If you are new to the area, arrange for interviews and ensure that people get to know you as a person i.e., number of children, where you're coming from, what your last job was, etc.

DOING MORE WITH LESS

By Jack Hutton, M.S.W.
Duncan Mental Health Centre
British Columbia

It has been ten years since we opened the Mental Health Centre in Duncan on Vancouver Island, British Columbia, and it now seems appropriate to comment on our experiences of trying to do more with less. This discussion will review our efforts to establish programs and services for the chronically mentally ill people of our community and surrounding areas in the absence of any significant program funds from the Provincial Ministry of Health. In order to establish these services, we have relied a great deal on community development efforts, thereby sharing the responsibility for the mentally ill with the community at large.

Over the last ten years, we have assisted in the development of a range of resources and services including a crisis line, activity centres, youth projects, day care centres, volunteer bureau, etc. With respect to community development, we have tended to go with community feelings and needs whenever possible; but on occasion we have made very independent and unilateral decisions as to our priorities and then searched out community support for them. For example, we made a decision approximatey four years ago to work towards the development of three new services: a group home for psychiatric patients; a day program based on a community; and work projects that would provide meaningful activity for those individuals interested and able to participate. Funding existed for the development of the group home but there was nothing for the other two proposed services.

In developing the latter two proposed services, we first looked for people willing to risk and willing to make a commitment. This is a difficult proposition as many organizations are unwilling to risk either going against public opinion or taking a chance on failure. The next stage, which also can create dilemmas, involves obtaining funding. You have to believe in the tooth fairy! In addition to that, persistence, ingenuity, nerve, and just plain stubbornness may do the job. However, we have found that the most significant factor is networking. All of our projects that have survived over the years have depended upon shared ownership and responsibility with a variety of local agencies and departments. No one group has owned these programs. In every such case, we have had to consider who the "stockholders" were, what was their stake in the project, and could it fit with the program's needs as a whole. In many ways, the chronic lack of funding has encouraged greater interdependency and co-operation amongst local resources.

In delivering the actual programs, we have tended to blur the roles of the various professional and volunteer staff involved, and this has eliminated a lot of stereotyping of roles. Now "you can't tell the players without a program."

Our major focus has been to keep in mind what the participant actually gets out of these programs. In approximately three years of operation, the community-based day program, known as Open Door, has provided a meaningful social and recreational program for an incredible mix of people of all ages, problems, and handicaps. This has created a feeling of community: a sense of belonging. Open Door functions three days a week and serves at least 100 people per week. It has a budget of approximately $4,300.00 from a range of sources. The program facilities include a church, the Community Centre, and Providence Farm. The Providence Community Farm is a new resource run by a non-profit society with the aim of reaching out to people who are in need and not easily accepted in the community at large. It is situated in a 400-acre site that includes farm buildings as well as a four-storey building that saw previous service as a residential school for a number of years. Our program consists of real work -- renovating and reactivating the farm -- and these activities have involved approximately 20 to 30 people a week. Our future plans involve some permanent jobs at the farm as well as the possibility of developing a sheltered workshop. The support network that helps to maintain these programs consists of private societies that sponsor the programs and manage volunteers and funds; the Cowichan & District Hospital Psychiatric Unit and Day Care Program, which provides staff and food two days per week; the Duncan Mental Health Centre, which provides some funding and staff support; and the People Encouraging People Advocates Group. The staffing of many aspects of the programming has been shared and, thus, costs are part of other budgets. The program has worked because we wanted to make it work. One cannot ignore the importance of the various personalities and styles. We have had tremendous help from volunteers and, in particular, have found our summer students to be an asset both in energy and idealism.

We have rediscovered the importance of starting small and taking it slow. We have tried to provide continuity and regularity to all of our programs and have not had hard-and-fast rules regarding intake or departure. It has been an open system not exclusively dependent on official governmental support; perhaps this has been a significant factor in its continued success.

HOSPITAL LINKAGE: LIAISON FACTORS IN THE SERVICES OF A COMMUNITY MENTAL HEALTH CENTRE

By: Grant W. Rathwell, M.W.S.,
Charles P. Hellon, M.B., F.R.C.P. (C)
Port Alberni Mental Health Centre
British Columbia

This workshop described service links between the Port Alberni Mental Health Centre, the local hospital psychiatric unit, and the community-based psychiatric day hospital. The staff of the Mental Health Centre consists of a clinical/child psychologist; community psychiatric nurse; a full-time (sessional) psychiatrist; and a psychiatric social worker/director. The geographic area served extends from the Alberni Valley on Vancouver Island to the west coast fishing and logging communities of Bamfield, Ucluelet, and Tofino. Total population in this area is approximately 35,000.

Reflecting community acceptance, the Mental Health Centre has experienced a progressive annual increase in referrals since it was established in 1972. Currently, referrals are averaging nine per week. The Centre staff have always worked to full caseload capacity, with varying waiting periods required for new referrals. Management of this heavy workload is aided by the presence of a community-based psychiatric day hospital that serves as a vital link between the Mental Health Centre and the local hospital psychiatric unit.

Referral Procedures

The single channel for referral to our Mental Health Centre is through any of the twenty-six local general practitioners. The major disadvantage to this referral system is that it prevents ready access in terms of self-referrals or "drop-ins." However, no referral procedure is flawless and it is felt that the following merits to this system outweigh the disadvantages:

1. An outreach element is built in because most of the people in the district are patients of the local general practitioners.
2. In addition to his sessional work at the Mental Health Centre, the psychiatrist has full practicing and admitting privileges at the local hospital. His daily responsibilities, both in the psychiatric unit and in the rest of the hospital, reinforce excellent communication channels for referral screening and case follow-up. Ongoing care and surveillance is also assured. For the most part, the physicians make appropriate referrals and, through mental health consultation, are able to refer elsewhere those cases which are not suitable for local treatment.

3. Referral by general practitioners minimizes the possibility of Mental Health Centre staff attempting to treat medical problems with psychiatric remedies.

4. Emergency cases can still be handled at the Mental Health Centre without departing from the referral procedure. Also the General Hospital has a 24-hour Emergency Department that can handle emergencies when Mental Health Centre staff are off duty.

Community Liaison Factors

The liaison between the Mental Health Centre and the hospital services (both in-patient and day hospital sections) is quite effective, particularly since the Mental Health Centre psychiatrist works in all three sections. Another important factor is the joint weekly meeting of the staffs of the three community psychiatric facilities, for case assignment, review and consultation, and planning.

An inter-agency conference is held every two weeks to co-ordinate the work of the various community agencies. The Mental Health Centre is thus able to call upon all other agencies as mental health needs are identified, or when back-up information is required. Consequently, communication lines between the allied agencies are excellent.

The Mental Health Centre relies upon and supports several community volunteer groups for assistance in providing needed services that would otherwise not be available due to the limitations of government funding. The Canadian Mental Health Association, the Vancouver Island Programs for Special Children, the Alberni Valley Homemaker Society, and the Port Alberni Family Guidance Association are some of the collaborating agencies in this network. One of the issues discussed during the workshop concerned major employers' responsibility for providing either direct funding for mental health care services or otherwise tangibly supporting improved community mental health care services and facilities.

Current Limitations to Delivery of Service

Mental Health secretarial services are of excellent quality but insufficient quantity. To date, all efforts to remedy the situation have produced only occasional and brief extensions to the existing half-time services. As the secretarial services are an essential link in the Mental Health Centre network, this chronic staff shortage is an impediment to smooth and responsive interaction with the community. In terms of office management, letters to referring physicians and other essential pieces of correspondence are dispatched promptly, but case notes have to be hand-written and there is no adequate compilation of performance data. Furthermore, secretarial and professional staff functions are continually interrupted by numerous phone calls; this is probably inevitable in a popular service.

The Alberni Valley presently has no long-term sheltered accommodations for psychiatric clients. It is anticipated that this problem will be remedied within the next year through the establishment of the Alberni Valley Mental Health Care Society, whose objective is the establishment of a 10-bed psychiatric boarding home. Thus, the hospital linkage system will be expanded to include a facility provided by a private society. There will still exist a definite need for sheltered work programs for some psychiatric clients, as well as an urgent need for a structured intensive residential treatment program for seriously disturbed adolescents. It is the experience of the Mental Health Centre staff that these services are essential in order to "tighten" the existing links of the community-based mental health services.

VOLUNTEERS IN RURAL COMMUNITY MENTAL HEALTH

Joan McIntyre
Co-ordinator of Volunteers
Trail, British Columbia Branch
Canadian Mental Health Association

This workshop was designed to aid professionals wishing to develop a volunteer component to rural community mental health programs. People actually working as volunteer co-ordinators, or in volunteer programs, would also benefit from these discussions.

How To Set Up A Volunteer Program

Although funding is a major problem in all programs, a paid co-ordinator is a necessity in order to ensure program continuity. It is felt that governmental funding would be more cost effective in the long run. If a volunteer program does not have a paid co-ordinator, it is likely that the program will eventually dissolve.

Recruitment

The initial stage to setting up a volunteer program, which is also an ongoing function of volunteerism, involves a recruitment process. Communities need to learn why volunteers are useful and necessary for community mental health activities. The need for volunteers and the roles they can fill can be discussed in newspaper articles and/or radio and T.V. talk shows. Advertising (including the "Help Wanted" columns) is another way of soliciting volunteers. One very effective way of educating the public about the need for mental health volunteers is through informal daily person-to-person contacts.

Training

Volunteers must be thoroughly trained and screened before entering service, and this responsibility rests on the mental health professionals in the field. In Trail, our initial training involves four sessions. The first session reviews the settings where the volunteers are needed: primarily hospitals and home visits. A mental health professional outlines types of mental disorders the volunteers might encounter in their work; this section of the training generally involves the use of some role playing. The next training session focusses on enhancing the communication skills of the volunteer. Again, the mental health professionals take an active role in this phase of the training. The third session is a panel discussion wherein local doctors, nurses, the volunteer co-ordinator, etc., cover the role of the volunteer in the various local facilities. The final session attempts to match the volunteer's interests and background with current needs. A "job application" form outlines the volunteer's occupational background, special skills or interests, and volunteer activity preferences. We have also found that a short list of simple "do's and don'ts" is a handy outline for volunteer to follow. These can be summarised as follows:

Do: Touch if comfortable to both of you.

Take an interest in photos and anecdotes people may wish to share with you.
Make a regular commitment.

Listen and take time to understand.

Respect patients' rights and dignities.

Don't: Be hurried.

Do everything for patients, clients, residents.

Interfere with the treatment plan. In other words, "ours is not to reason why, ours is but to do or die."

Fund-Raising Activities

A critical factor in the continued success of any volunteer program is the creative pursuit of fund-raising activities. At Trail, we have found the following to be useful:

1. The United Way
2. Memberships and donations
3. Challenges such as ball games or beard-growing contests
4. T-shirt sales
5. Candy, gum and match machines
6. Arts and crafts fairs, flea markets, client-made arts and crafts
7. Bridge, Whist, and Cribbage charity tournaments
8. Community program grants
9. Ministry of Health grants
10. Thrift store
11. Raffles
12. Bingoes

One final comment: In our opinion, some sort of standardised Province-wide guidelines for setting up volunteer programs would be useful. At present in British Columbia there is little interaction or cohesion amongst the various groups of mental health volunteers. This limits the sharing of ideas and activities that have proved to be useful; it also hinders the identification of common problem areas.

ETHNIC GROUPS

Ricki Devlin
Pacific Regional Health Educator
Health and Welfare Canada
Vancouver, British Columbia

This workshop was designed to allow participants to explore the impact that cross-cultural differences can have on rural mental health programming. The workshop orientation was experiential and the following areas were examined:

1. The influence of our own ethnic base on our views of the world.
2. The ways we tend to learn our prejudices and biases.
3. The impact of cultural shock on both the minority and the majority culture.
4. The varying influences of cultural differences.
5. The recognition that most cultures adhere to similar values, with the apparent differences mainly a consequence of differing priorities.
6. The recognition that, when one culture is overly influenced by another, the consequence is that members of the minority culture eventually do not identify with either culture.

In terms of rural mental health programming concerns, a number of recommendations arose from the workshop:

1. Rural mental health workers should make use of available cross-cultural educational programs. In western Canada these programs can be obtained from Drs. Sealey and MacDonald at the University of Manitoba; the Resource Centre at Simon Fraser University; and Dr. Butenthal at the University of British Columbia.
2. Rural mental health workers need to develop an awareness of any differences between their own ethnic/cultural needs and those of their host communities.
3. There is a definite need for the training of indigenous mental health workers.
4. It is important to involve ethnic groups in program development. It is equally important to involve them in networks that are currently in existance.

5. Rural mental health workers need to continue to learn and understand the antecedents of differing cultural behaviours.

6. "Know thyself." Again, it is very important to understand and recognize your own cultural biases.

7. Be aware of all ethnic groups within your host community. Be careful not to over-identify with any one group.